

Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF JULY 7, 1958

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JUL 7 '58


THE CHILDREN'S HOSPITAL



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also in this issue

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Ability to Pay?

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1. Proctor, R. C.: *Dis. Nerv. Sys.* 18:223, 1957. 2. Feuss, C. D., and Gragg, L., Jr.: *Dis. Nerv. Sys.* 18:29, 1957. 3. Coats, E. A., and Gray, R. W.: *Dis. Nerv. Sys.* 18:191, 1957. Registered Trademark: Quiactin

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NEWS BRIEFS

LET U.S. M.D.s CHALLENGE RUSSIANS to a longevity race, urges John T. Connor, president of Merck & Co. The goal: a 75-year life expectancy for patients. "Let's pit our patient-oriented system...against their state-oriented one."

A FAIR PRICE FOR YOUR PRACTICE? The Los Angeles medical society suggests you charge the appraised value of furniture and equipment plus these percentages of post-sale receipts from patients on your records at time of sale: 30% the first year, 20% the second, 5% the third.

RELATIVE VALUE SCALES continue to gain adherents. The Kansas State Medical Society recently became the fifth to assign point values to various listed procedures. The Kansas scale covers medicine, surgery and anesthesia, radiology, and pathology. And unlike scales of some other states, it correlates point values of procedures in all 4 fields.

DOCTORS WHO ALWAYS CHARGE TOP FEES to insured patients harm voluntary health plans more than do outright fee gougers, says a recent Saturday Evening Post article. Gougers, it explains, can be spotted and stopped. But with constant top-fee chargers, the insurance men can do only one thing: keep hiking premiums.

HEALTH INSURANCE THROUGH SOCIAL SECURITY has nursing's blessing now. The American Nurses' Association says the aged and disabled need it.

MUST BLUE CROSS BE BROKE to get a premium increase? Apparently. New York's Associated Hospital Service asked for a 40% hike last November, said its free funds would be gone June 30 without it. "No," said state officials: "Dig into statutory reserves first." In April, the plan applied again, said it needed the 40% to stay solvent. Now a hike's been granted. Effective Sept. 15, A.H.S. can raise rates—22.3%.

STATUS OF KINTNER-TYPE PENSION PLANS is still in doubt. Decision on whether association of M.D.s can have the tax advantages of a corporation is expected after Congress adjourns.

DOCTORS ARE GUILTY of "unlawful...restraint of a lawful pursuit" when they discipline colleagues who cooperate with closed-panel health plans. That's what labor attorney Horace Hansen recently told union doctors at the National Conference on Labor Health Services. And he added: "The courts will effect remedies under antitrust laws...Lay-sponsored [health] plans ...have prevailed in every lawsuit they have brought against offending medical societies."

NEWS BRIEFS

HOW SIX PROFESSIONS RATE with the public is shown in a new study by the Health Information Foundation. From the top down, professional people rank as follows: physicians, dentists, pharmacists, nurses, lawyers, teachers.

FORAND BILL GOT NO MENTION through 30 pages of Marion B. Folsom's recent testimony before House Ways and Means Committee. So Rep. Forand finally asked Folsom what he thought of bill. Said the Secretary of Health, Education, and Welfare: "I see no need for it just now."

CHISELING PHYSICIANS cost service-plan subscribers "many millions of dollars annually," says a new study by the Foundation on Employee Health, Medical Care, and Welfare. How? By not accepting the plans' benefits as full payment, says the report. And it urges that medical societies discipline such M.D.s and that they be dropped from "participating" lists.

DOCTORS' COMPLAINTS about excessive malpractice verdicts are leaving most judges cold, implies New York Supreme Court Justice Walter R. Hart. Can damage awards be "excessive," he asks, if "human lives and wrecked bodies" are involved? He adds: "Prize bulls have [sold] for \$200,000 and a champion race horse for \$700,000."

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*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JULY 7, 1958

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***How to Fight the Forand Bill* 71**

If doctors want to block Federal medicine for the aged, this M.D. warns, they've got to offer something better: specifically, Blue Cross and Blue Shield on a paid-up-at-65 basis

***Should You Base Fees on Ability to Pay?* 76**

Most doctors still think so—and most patients seem to approve—according to this study based on 3,000 interviews

***Your Handwriting Gives You Away* 80**

It reveals whether you're warm or cold, a dreamer or a doer, says Dr. W. M. Knowles. Here are his grapho-analyses of Drs. David B. Allman, Leroy E. Burney, Morris Fishbein, Karl Menninger, I. S. Ravdin, and Paul Dudley White

***Today's Young Doctors Start Fast* 88**

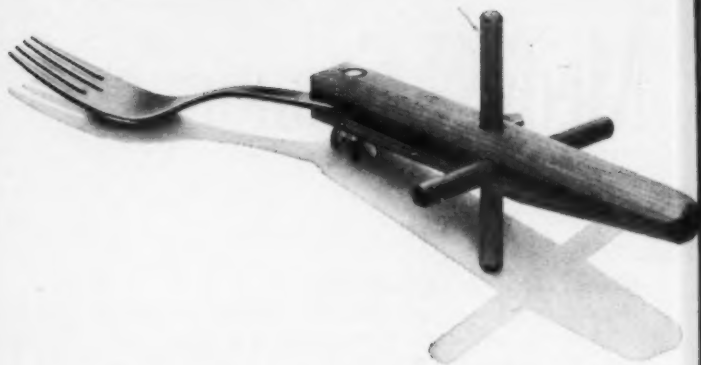
The 'starvation period' you may have gone through is notably shorter now, if it exists at all, this new study shows

***Overdue Accounts: What Are They Worth?* 95**

You stand to collect only \$71 on a 6-month-old bill for \$100. Here's how the value of your unpaid accounts keeps dropping

MORE ►

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This doctor has a black list of types of checks he won't accept—and a set of money-saving safeguards for the ones he does

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They're catching on in more and more states. Here's one example of how generalists operate an accredited hospital and even tell board men what they're doing wrong in surgery

What Tax-Sheltered Investments Offer You ... 177

Want tax-free income? Want to build up your retirement capital? Want to create capital gains that you can cash in with the least tax loss? These basic investment tips will help you

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bacteriostasis
in
oropharyngeal
infections
and
following
tonsillectomy



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1. Granberry, C., and Beatrous, W. P.: E.E.N.T. Mo. 36:294 (May) 1957. 2. Rittenhouse, E. A.: E.E.N.T. Mo. 36:406 (July) 1957. 3. Fox, S. L.: Clin. Med. 4:699 (June) 1957.

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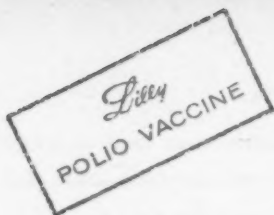
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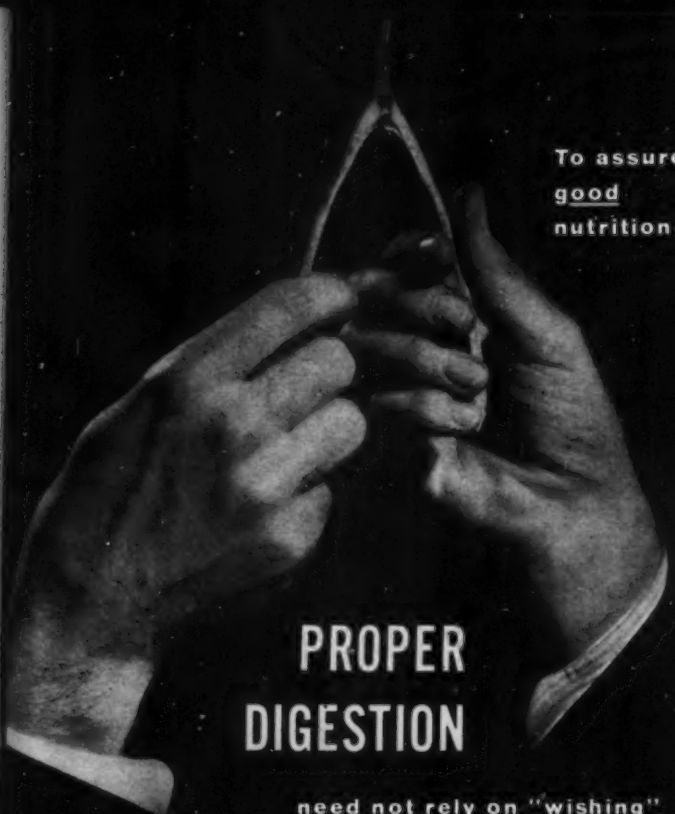
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*Rowell, G. H., Jr., Am. Pract. & Digest Treat. 8:1020, 1957.



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Letters

Malpractice Time Bombs

SIRS: Malpractice lawsuits may be filed years after the alleged injurious action. In northern California, the malpractice defense committees have found this latent period to be at least five years. And some claims may not be presented for fifteen or twenty years. This lengthy latent period is peculiar to medical liability.

So when the American College of Surgeons allegedly sees "clear indications of success" for its anti-malpractice program only two years after its inception, it's making a premature claim.

Carl Goetsch, M.D.
Berkeley, Calif.

Aides Can Be Trained

SIRS: In a recent letter to MEDICAL ECONOMICS, an R.N. complains that low-paid girls with "little education and no medical training" give injections and perform routine lab work in doctor's offices. True, some aides do this—I, for one. But hardly on our own.

I have only an average education. I had no medical training prior to my present job. But the doctor has trained me. I feel that after six years under his supervision and instruction, I've proved satisfactory. And I take home a darn nice salary from a boss who appreciates my efforts.

Jo Alice Leavell
Amarillo, Texas

Professional Courtesy

SIRS: Like another of your correspondents, I feel flattered when my colleagues send me their relatives. It's an even greater compliment when a certain group of the profession send me their mothers, sisters, wives, sweethearts, etc., but send *paying* patients to a more "remunerative" practitioner. Still, while flattered, I must admit I also get somewhat peeved.

G. L. Moench, M.D.
New York, N.Y.

SIRS: I enjoyed "How Much Professional Courtesy for Non-

LETTERS

M.D.s?" It may interest your readers to know that many members of my own profession treat M.D.s and their families besides other non-D.O.s—and, as a rule, we do not charge members of the medical profession for our services. We feel they've received as much education and training as we have and deserve all courtesies.

Robert C. Browning, D.O.
Tacoma, Wash.

Army Medics

SIRS: In your May 12 News, you gave an outdated figure for the total number of physicians now in the Army Medical Corps, Regular Army. Correct total, as of December, 1957, is 1,551, not 1,399.

W. T. Parker
Asst. Chief, Technical Liaison Office
Office of the Surgeon General

We said nearly half the Army doctors are certified. But using the later total as a basis for figuring, it's 32 per cent.—Ed.

Panel Plan's Record

SIRS: The perinatal rate reported by The Health Insurance Plan of Greater New York deserves physicians' universal praise instead of the criticism you quote. I'm sure all of us in medicine work toward the same goal of better health for the individual and the community. H.I.P.'s remarkably low perinatal record certainly achieves this. And

it's hardly explained away by suggesting, as do some critics, that difficult cases are withdrawn from H.I.P. by subscribers' transferring to fee-for-service physicians. For this involves only a few cases each year.

The real explanation for H.I.P.'s magnificent results is the ready availability of consultants without additional cost, plus the meticulous prenatal care given by H.I.P. physicians.

Alan F. Guttmacher, M.D.
Obstetrician-Gynecologist-in-Chief
Mount Sinai Hospital
New York, N.Y.

Got Building Woes?

SIRS: Not long ago I put up my own office—a small suburban building. As soon as it was finished, I made the final payment to the contractor, a highly reputable man.

Thirty days later, I was taken aback when the flooring subcontractor threatened to put a lien on my building because the contractor hadn't paid him. The contractor's story was that all his money was tied up and he couldn't pay the flooring man just yet. I then checked with the wiring subcontractor and found he hadn't been paid either.

My attorney told me to sit tight until the end of the four-month grace period that this state allows before work liens can be filed

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and low incidence
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One tablet provides all-day or all-night relief.

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Laboratories, Inc., Philadelphia 32, Pa.

Beale, H. D.; Rowley, F. A., and Figley, K. D. J. Allergy, 23:521-524 Nov., 1954.

LETTERS

against a building. Fortunately for me, the contractor did pay off the subcontractors within that period. But in the meantime I'd had considerable worry over the situation.

I know now that there's a way to eliminate such uncertainty, and I'd like to pass the news along to other readers who might find it useful:

If your contractor has a satisfactory rating, you can buy a form of building insurance called a "performance bond." This not only insures payment of debts but also completion of the building. It costs 1 per cent of the total contracted building costs.

J. J. Faust, M.D.
Tyler, Tex.

Medical Writing Costs

SIRS: Dr. Richard H. Orr seems to me to be misleading your readers in his lament about the high cost of writing medical books. He puts the expense at \$3,600 to \$6,500 for a 300-page book. I've written four books, each longer than that—and considerably less costly. It has been my experience, at least, that a 300-page book need cost no more than about \$550 to prepare.

Dr. Orr places the expense of pictures alone at between \$1,750 and \$3,000. This is about ten times more than I've ever had to shell out. His hypothetical 300-page book would have 150 pictures. But with the possible exception of a radiologist, who wants a picture

on every other page? As I see it, a 300-page medical book probably needs only about twenty illustrations, at a maximum cost of \$200.

Many medical illustrations can be had free from laboratories, hospitals, equipment makers, museums, and pharmaceutical houses. Many can be made inexpensively in medical-illustration laboratories at hospitals and medical schools. And a physician who presumes to write a book must have lectured on the subject; so he probably has a gallery of illustrations in his files.

Dr. Orr estimates it costs up to \$3,000 to have that 300-page book typed. In New York City the going rate is 50 cents per page, with one carbon. A 300-page book takes about 750 manuscript pages. Unless you're going to have it redone again and again, your typing costs may be closer to \$300 than to \$3,000.

And Dr. Orr's price tag of \$350 to \$500 for research is fair only if the writer hires someone to do all his citation checking. But in my experience no doctor ever writes a book unless he himself is thoroughly familiar with the literature of his specialty.

I agree that royalties won't make a doctor rich. Still, Dr. Orr shouldn't spread his wet blanket too far.

Henry A. Davidson, M.D.
Cedar Grove, N.J.

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If all the Gantrisin tablets* produced and used since the introduction of this single, soluble sulfonamide were placed "end to end," the distance would exceed 24,000 miles--more than enough to encircle the globe at the equator.

This acceptance by the medical profession is overwhelming evidence of the clinical usefulness, efficacy and safety of Gantrisin.

*More than 3 billion tablets (liquids and other forms not included).

GANTRISIN®—brand of sulfisoxazole



Original Research in Medicine and Chemistry

ROCHE LABORATORIES

Division of Hoffmann-La Roche Inc
Nutley 10, N. J.

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TAKE A NEW LOOK AT FOOD ALLERGENS*—TAKE A LOOK AT NEW DIMETANE

*Egg food—source of highly potent allergens. Typical egg
allergens: food; shampoos; hair; food used to prepare leather,
chambers, shoes; cutlery; food for painting material
and tooth powder; gloves made from fish products.

In a recent 140-patient study¹ DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

DIMETANE Extentabs (12 mg. each, coated) provide antihistamine effects daylong or nightlong for 10-12 hours. Tablets (4 mg. each, scored) or pleasant-tasting Elixir (2 mg./5 cc.) may be prescribed t.i.d. or q.i.d., or as supplementary dosage to Extentabs in acute allergic situations. A. H. ROBINS CO., INC., Richmond 20, Virginia. Ethical Pharmaceuticals of Merit Since 1878.

Robins

Dimetane
(PABRODOLAPINE HALATE)
EXTENTABS • TABLETS • ELIXIR



 <p><i>Blender</i></p>	 <p><i>Milk</i></p>	 <p><i>Cottage Cheese</i></p>
 <p><i>Tomato Juice</i></p>	 <p><i>Strained Carrots</i></p>	 <p><i>Eggs</i></p>
 <p><i>Fruit Drinks</i></p>	 <p><i>Lemon and Mint</i></p>	

*With a blender or an egg beater
almost any food can be used*

*...and may we
remind you
that a glass
of beer can
make full-
liquid diets more
palatable?*

The Full-Liquid Diet

• Strained chicken in milk makes "bisque"—in tomato juice it's "creole." Your patient may like cottage cheese whipped into milk flavored with chocolate and mint. Strained carrots go in milk flavored with nutmeg or pineapple juice. An egg or skim milk powder adds a protein bonus.

Strained fruits in chilled fruit juices are a zesty treat with a squeeze of

lemon or a touch of mint.

Of course, only you can tell your patient just which food he can and must have. And if you feel that a glass of beer* is acceptable in his specific condition, it may provide an incentive he needs to stay within the limits you set.

*pH 4.3; 104 calories/8 oz. glass
(Average of American Beers)

United States Brewers Foundation
Beer—America's Beverage of Moderation



If you'd like reprints of this and 11 other dietary suggestions, please write United States Brewers Foundation, 535 Fifth Ave., New York 17, N. Y.



postnasal drip orally relief in minutes...lasts for hours

Postnasal drip can be controlled with a single timed-release TRIAMINIC TABLET. Mucus flow is decreased — annoying throat-clearing need no longer interrupt sleep. Equally welcome and effective relief is obtained in allergic rhinitis, sinusitis and the respiratory congestion of the common cold. TRIAMINIC acts *systemically* to clear the nasal and paranasal passages promptly and keep them clear for 6 to 8 hours.

Each timed-release TRIAMINIC TABLET contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrimidine maleate	25 mg.

Dosage: For nasal congestion, 1 tablet in the morning, mid-afternoon and at bedtime, if needed. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Triaminic for the Pediatric Patient
New TRIAMINIC JUVETTES*, providing easy-to-swallow half-dosages for the 6-to 12-year-old child, retaining timed-release construction for prolonged relief.

TRIAMINIC SYRUP, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ TRIAMINIC TABLET or ½ TRIAMINIC JUVETTES.

*Trademark

"Besides avoiding the risk of nasal mucosal pathology associated with topical application, the oral administration of decongestants provides better distribution via the blood stream, and furnishes decongestion in areas that cannot be reached by topical administration. Oral administration also provides longer duration of action. Post-therapeutic resurgence or 'rebound' is rarely encountered."

Lhotta, F. M.: *ILL. M. J.* 112:259 (Dec.) 1957.

"Timed-release" keeps each TRIAMINIC tablet working for 6 to 8 hours to provide uninterrupted freedom from congestion. Especially valuable in providing night-long relief from the discomfort of post-nasal drip.

First—the outer layer dissolves within minutes to produce 3 to 4 hours of relief



Then—the inner core disintegrates to give 3 to 4 more hours of relief

Triaminic® "timed-release" tablets

stop running noses . . .   and open stuffed noses orally

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

MEDICAL ECONOMICS • JULY 7, 1958 27

long day ahead
morning sun glare — eyes irritated
can't read — coach smoky
leave the work — let's lunch
back to work — eyes worse
take afternoon off — see doctor
pick up VISINE — home again
let's try the drops
nice dinner — read the paper
eyes comfortable — good TV play
use VISINE — bed 11:30
long day behind
turned out well

see the difference



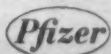
new VISINE® EYE DROPS

brand of tetrahydrozoline hydrochloride

"an excellent ophthalmic decongestant . . ."¹

almost immediate relief of hyperemia, soreness, itching, burning, tearing — no rebound vasodilatation, mydriasis, photophobia or systemic effects. supplied: in 1/2 oz. bottles, 0.05% tetrahydrozoline hydrochloride in a solution containing sodium chloride, boric acid, sodium borate; with sterile eye dropper.

1. Grossmann, E. E., and Lehman, R. H.: Am. J. Ophth. 42:121, 1956.



PFIZER LABORATORIES, Brooklyn 6, New York
Division, Chas. Pfizer & Co., Inc.

News

Doctors Crack Down On 'Clinic' Signs

"Dear Doctor: We note that you call your medical offices a clinic. For that reason please give us the following information. . ."

That's the gist of a query being sent to certain Chicago doctors. The idea is to remind them that misleading signs violate their medical society's code.

Some time ago, the Chicago Medical Society passed a resolution defining a medical clinic as follows: "A clinic is the formal association . . . of licensed physicians providing services in one or more medical fields or specialties, with income . . . distributed to its members according to some prearranged plan . . ."

"A clinic may be a place for diagnosis or for the care of one special or certain variety of ailments," the resolution continued. "But in such cases the staff should be made up of [specialists in] these subjects and should provide all an-

cillary services such as X-ray, laboratory, etc." The society further ruled its doctors may not display "clinic" signs "unless such organization . . . does actually exist."

Most Chicago doctors abide by this ruling. But a few apparently don't. And they're the ones whose "clinics" the society wants to know more about. Its letter of inquiry asks twenty-six questions, ranging from "What are the qualifications of your clinic's specialists?" to "Who is in charge of the X-ray department?" Society officers hope the letter will help its recipients reconsider whether they actually should have a "clinic" sign posted outside their offices.

TV 'Doctors' Get Scolded —But Not Whipped

Television's white-coat hucksters have long infuriated sensitive medical men. And quite rightly, says The New York Times. In an editorial commending the New York State Medical Society's recent res-

on the problem



A POINT OF VIEW IN '55 "At this time, it appears that the problem of antibiotic-resistant bacteria is the greatest fear in the future with chronic infections of the ... urinary tract ..."¹

A POINT OF FACT IN '58 "... This prediction has proved to be correct for both gram-positive and gram-negative organisms."²

... WITH ONE NOTABLE EXCEPTION "... studies indicate that microorganisms, in vitro and in vivo, do not appear to develop resistance to FURADANTIN."³

EATON LABORATORIES, NORWICH, NEW YORK

problem with antibiotic-resistant bacteria

for acute and chronic
genitourinary tract infections

FURADANTIN®


brand of nitrofurantoin

AVERAGE FURADANTIN DOSAGE: In acute, complicated or refractory cases and in chronic infections—100 mg. q.i.d., with meals and with food or milk on retiring.

REFERENCES: 1. Flippin, H. F.: *Virginia M. Month.* 82:435, 1955. 2. Caswell, H. T. et al.: *Surg Gyn Obst.* 106:1, 1958. 3. Nesbitt, R. E. L. Jr., and Young, J. E.: *Obst. Gyn.*, N. Y. 10:89, 1957.

NOW, for hospitalized patients, for severe urinary tract infections when peroral administration of FURADANTIN is not feasible and for serious infections as septicemia (bacteremia): **FURADANTIN Intravenous Solution**



NITROFURANS . . . a new class of antimicrobials . . .  neither antibiotics nor sulfonamides

olution against "the abuse of the word 'doctors' on radio and television commercials," The Times has this to say:

"What is coming over the air now is an insult to the intelligence of the listener and viewer, a slur on the medical profession, and an outright danger to the gullible. . . It is a sorry commentary on our enlightenment when the old 'snake oil' technique can be used on millions of persons to make millions of dollars in profits. . . It is high time to take those phony 'doctors' off the air."

But it seems unlikely that Madison Avenue's white-coat commercials are in for an early demise. A recent agreement between the Federal Trade Commission and one advertiser appears to give the TV "doctor" a new lease on life. Here's the story:

Last year, the F.T.C. brought suit against the American Chicle Company, which manufactures Roloids (an antacid). The commission charged that, in using actors posing as M.D.s, Roloids commercials falsely implied that physicians in general recommended the product. Presumably, this was the opening shot in a planned campaign against such commercials. But the manufacturer chose to sit down with F.T.C. lawyers and work out a settlement rather than go to court. And the resultant agreement appears less a shot at

than a shot in the arm for the TV "doctor."

The F.T.C. did win two points. The recent consent decree prohibits Roloids from stating in one commercial that "stomach acid is capable of burning a hole in a cloth napkin." And the company also agrees not to use white-coated "representatives" of the medical profession in their other commercial to imply that the profession as a whole recommends the product. But there's a catch: It *may* use such "representatives" if "the representation is limited to numbers of doctors not greater than has been ascertained to be the fact."

This last clause apparently offers a loophole big enough for many white coats. Why? Because an F.T.C. survey has reportedly turned up at least 3,000 physicians who do recommend Roloids. So advertisers in general are said to believe they have a right to go on as before, as long as they accompany any medical claim with a statement specifying the number of doctors on their side.

Where to Find the Fat

If weight-reduction interests you as a subspecialty, better see if there's a TOPS chapter in your neighborhood. TOPS stands for "Take Off Pounds Sensibly." It's the fat man's equivalent of Alcoholics Anonymous. The 20,000-

Now 1 R_x for 2-dimensional menopausal therapy

manages both the psychic and somatic symptoms

*and relieves emotional stress in the menopause
and treats somatic disturbances due to ovarian decline*

Milprem*

*TRADE-MARK

MILTOWN® + CONJUGATED ESTROGENS (EQUINE)
A PROVEN TRANQUILIZER + A PROVEN ESTROGEN

SUPPLIED: Bottles of 60 tablets.

EACH TABLET CONTAINS:

Miltown® (meprobamate, Wallace)	400 mg.
2-methyl-2-n-propyl-1,3-propanediol dicarbamate	
Conjugated Estrogens (equine)	0.4 mg.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

Literature and samples on request.

W® WALLACE LABORATORIES, New Brunswick, N. J. CNP-6564-68



NEWS

member organization was founded ten years ago by Mrs. Esther S. Manz of Milwaukee, upon the suggestion of her physician, Dr. C. F. McDonald. It's said to have a good record of resisting commercialized fad diets and of emphasizing physician-guidance.

State Medicine Called a 'Very Real' Menace

The threat of Government-run medicine may seem less immediate than it was a few years ago. But at least one health insurance official warns that it's still "very real and imminent." Says John W. Castellucci, vice president of Blue Shield Medical Care Plans:

"The proponents of Government health insurance have only abandoned their frontal assault." What they couldn't accomplish openly they're now trying to achieve indirectly. How? Through "legislation that by degrees chips away first one then another freedom of private practice."

There are bills now before Congress, he maintains, "that can undermine the foundations of private medical practice as surely and as inevitably as any complete program of compulsory health insurance." One such bill: Representative Aimé Forand's proposal to give Government-financed medical care to the aged. Castellucci

new... dip 1 strip...read 2 tests! **URISTIX**

TRADEMARK

REAGENT STRIPS

colorimetric "dip-and-read" combination test
for PROTEIN and GLUCOSE in urine.
Available: Bottles of 125.



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"FENCED IN" BY ALLERGY



Lilly

QUALITY / RESEARCH / INTEGRITY

CO-PYRONIL* a way of escape . . .



*'Co-Pyronil' (Pyrrolbutamine Compound, Lilly)

Pulvules



Suspension



Pediatric Pulvules



from hay fever and other allergies

...acts fast to provide unusually long-lasting relief

'Co-Pyronil' combines a long-acting and a short-acting anti-histamine with a synergistic sympathomimetic. It usually begins to combat symptoms within fifteen to thirty minutes and eliminates them for as long as twelve hours.

Thus, you can give your hay-fever patients and other allergy victims remarkably complete relief on a dosage of only two or three pulvules daily.

Prescribe 'Co-Pyronil' in any of these three convenient forms:

PULVULES CO-PYRONIL

Each green-and-yellow pulvule provides:

'Pyrnil' (Pyrrobutamine, Lilly)	15 mg.
'Histadyl' (Thenylpyramine, Lilly)	25 mg.
'Clopane Hydrochloride'	
(Cyclopentamine Hydrochloride, Lilly).	12.5 mg.

SUSPENSION CO-PYRONIL

Each tasty 5-cc. teaspoonful provides active ingredients equivalent to one-half the formula of Pulvules 'Co-Pyronil.'

PEDIATRIC PULVULES CO-PYRONIL

Each tiny red pulvule provides one-half the formula of the adult pulvule.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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says advocates of Federal health insurance are "satisfied that it can be attained by. . . legislation like the Forand bill."

And he believes it's up to the nation's doctors to nip the threat in the bud: "The medical profession through its Blue Shield plans must [work toward] extensions in voluntary coverage." That way, he adds, private medicine can make "any kind of Government...health care unnecessary."

Would You Rather Not Be Misquoted? Don't Talk

"They quoted me out of context! And anyway, I thought that meeting was off the record." So said one unhappy physician after an off-hand remark he'd made at a recent panel discussion hit the headlines. But Robert M. Cunningham Jr., editor of *The Modern Hospital*, insists that no such complaint is ever justified.

"Everything that is quoted is quoted out of context except the verbatim transcripts of entire speeches or discussions," he points out. "The only way to make certain a statement will not be quoted out of context is not to make it."

What's more, he adds, "there can be no absolute certainty that anything is off the record when more than one person is present. And it is absolutely certain that nothing is off the record when

there are 200 people in the room."

Editor Cunningham's Rx for doctors who are "sensitive or cautious": They should "keep their mouths shut—especially when there are a few hundred people around."

Mutual-Fund Owners Look Like This

If you own mutual funds and you're in the \$15,000-to-\$20,000 income group, your over-all financial picture should look something like this: You have \$7,169 invested in the funds and \$25,560 in corporate stocks; you have another \$7,314 in bank accounts and U.S. savings bonds; and you carry \$27,516 worth of life insurance.

Who says so? The National Association of Investment Companies, that's who. A recent N.A.I.C. study of "Mr. Mutual Fund Investor" also discloses that the average such shareholder is 55 years old and that there's a four-to-one chance he *isn't* a professional man.

How to Hit Back at Suspected Swindlers

It's proverbial that doctors' names are on every sucker list. Perhaps they wouldn't be if more doctors bit back when bitten. Here are the best ways to do it, according to *Changing Times*, *The Kiplinger Magazine*:

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Provides therapeutic quantities of all known hematinic factors

Potent 'Trinsicon' offers complete and convenient anemia therapy plus maximum absorption and tolerance. Just two Pulvules 'Trinsicon' daily produce a standard response in the average uncomplicated case of pernicious anemia (and related megaloblastic anemias) and provide at

least an average dose of iron for hypochromic anemias, including nutritional deficiency types. The intrinsic factor in the 'Trinsicon' formula enhances (never inhibits) vitamin B₁₂ absorption.

Available in bottles of 60 and 500.

*'Trinsicon' (Hematinic Concentrate with Intrinsic Factor, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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¶ Stock or bond swindle? Report it to the Director of the Division of Trading and Exchanges, Securities and Exchange Commission, Washington 25, D.C.

¶ Deceptive insurance? The insurance commissioner of your state would like to hear the details from you.

¶ Suspicious deal offered to you through the mails? Your local postmaster can get the Post Office inspectors on the case.

¶ Misleading advertisement? Pass the word to the Bureau of Investigation, Federal Trade Commission, Washington 25, D.C.

Druggists Urged to End Discounts to Doctors

"The physician expects a discount [on drugs he buys] under the premise of Rank Has Its Privileges, due to the brainwashing he has been subjected to since his student days: He is a doctor, and society owes it to him." But the pharmacist shouldn't encourage such an attitude, one pharmaceutical leader told a recent pharmacists' convention.

For one thing, explained Jacob Migdall, who's a Fellow of the American College of Apothecaries, the practice of selling drugs cut-rate to medical men is "reprehensible." The druggist's discount is actually "a rebate or kickback to physicians." As such, it's "unlaw-

ful. . . and condemned by medical and pharmaceutical codes of ethics," he warned his colleagues.

He admitted that discount sales are common practice. But he deplored the motivation behind them: Druggists hope to "ingratiate themselves" with doctors so that the latter will "steer, direct, or command the patient" to their stores; or else the pharmacists court "the reciprocity of professional courtesy." On both counts, Migdall claimed, his generous colleagues get short-changed.

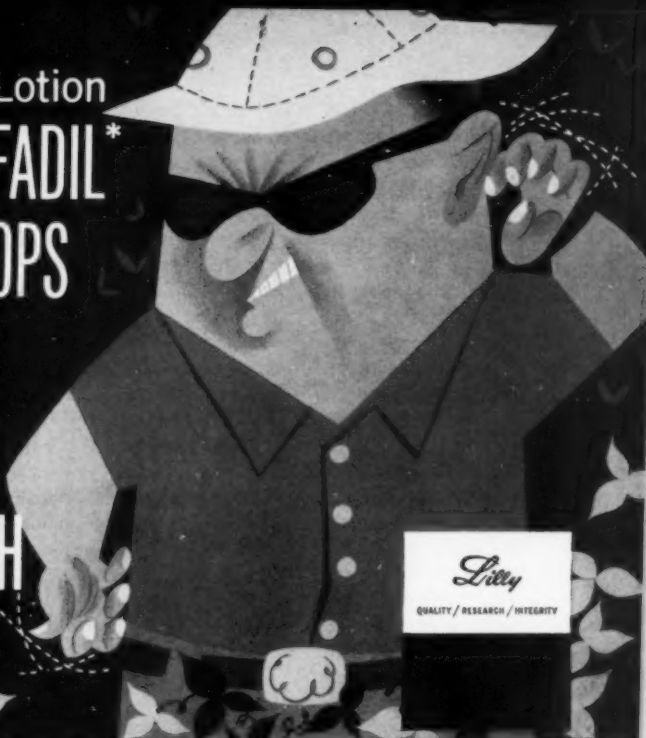
The pharmacists only *think* they're ingratiating themselves, he explained. Actually, "the doctor is totally unaware" of such friendly gestures and usually "feels that the . . . pharmacist is robbing him."

Nor do physicians generally reciprocate by granting professional courtesy to druggists, according to Migdall: Those who claim to do so simply charge a "padded fee less 25 per cent, which equals the regular fee after all."^{*}

Meanwhile, the cooperative druggist suffers a loss of "from 5 cents to 30 cents on each gross dollar of office supplies sold to physicians," said Migdall. And "this loss is accentuated" because

^{*}Of some 1,000 doctors surveyed recently, nearly half told MEDICAL ECONOMICS they make no charge to druggists whom they know. Another one-third said they always give such men a discount. And 29 per cent reported that they give a discount to all druggists. See "How Much Professional Courtesy for Non-M.D.s?" (April 14 issue).

Lotion
SURFADIL*
 STOPS
 PAIN
 AND
 ITCH



Anesthetic plus antihistaminic action assures prompt, prolonged relief

Lotion 'Surfadil' combines a soothing anesthetic with an effective antihistamine and a protective adsorbent.

It is useful for treating summer's most common skin problems: rashes due to weed poisoning, insect bites, heat rash, and sunburn.

Use Lotion 'Surfadil' to help protect your sunburn-prone patients, too. The ingredient titanium dioxide covers the skin with a translucent

"shield" that screens the sun's rays.

Skin tone in color and virtually odorless, Lotion 'Surfadil' does not readily rub off but washes off easily

Each 100 cc. contain:

- 'Histadyl' (Thenylpyramine, Lilly) . . . 2 Gm.
- 'Surfacaine' (Cyclomethycaine, Lilly) 0.5 Gm.
- Titanium Dioxide 5 Gm.

Available in 75-cc. plastic containers and in pint bottles.

*'Surfadil' (Cyclomethycaine and Thenylpyramine, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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"the physician is generally a slow payer, due to his rank, taking as much as ninety days [to pay] . . . In effect, the physician is borrowing money without interest at the expense of the pharmacist."

Jacob Migdall's advice to his fellow-druggists: "Retail all non-professional sales to physicians at regular selling prices. [And] invoice professional office supplies to physicians at cost plus 50 per cent to bring the price up to the break-even mark."

Do his colleagues seem to be flocking to follow this counsel? Not all of them, at any rate. The magazine *American Druggist* reports that an Auburn, Wash., pharmacist has "initiated a new policy in order to become personally acquainted with local physicians." He has invited any doctor to drop by his store at any time in order to replace items in his bag—at no charge.

Another Argument for Mental-Ills Coverage

Is your diagnosis ever influenced by the kind of health insurance coverage the patient has? It may well be, whenever the disorder is psychosomatic rather than organic, asserts Dr. Paul J. Poinard of Pennsylvania's commission on mental hygiene.

There's a "great financial premium on organic diagnoses," he says,

because most insurance contracts don't pay off for mental ills.

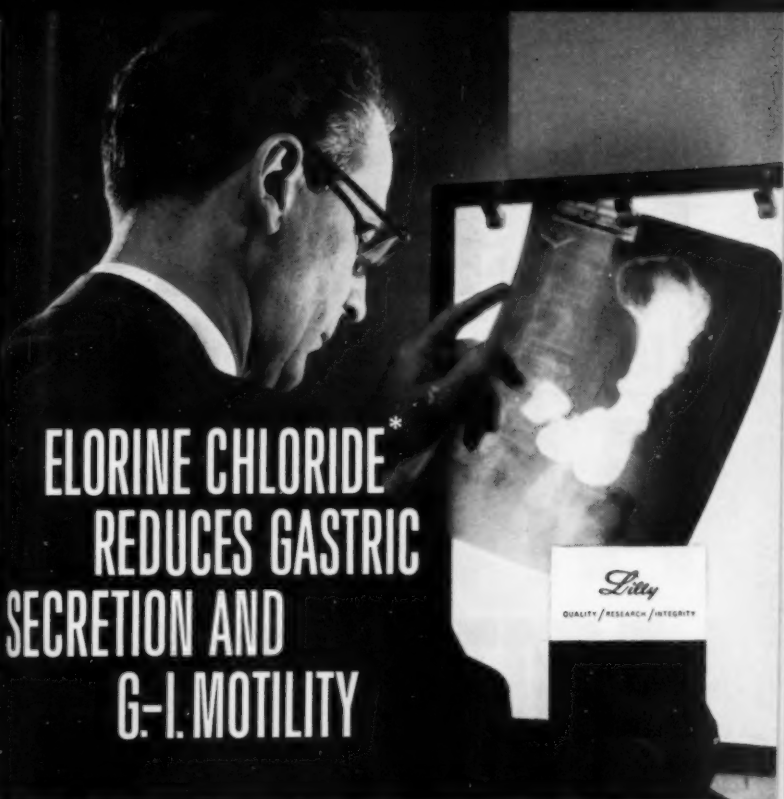
The doctor with a patient whose illness is basically mental must choose between "making a complete diagnosis, as a result of which his patient will suffer financially, or making an incomplete . . . diagnosis so that his patient may derive greater benefits," explains Dr. Poinard. He cites this example:

"A patient [hospitalized] with the diagnosis of paroxysmal tachycardia . . . would be entitled to complete medical insurance coverage. [But] if his tachycardia is due to anxiety and a more . . . accurate diagnosis is established, i.e., psychoneurosis," he may get little or nothing. So doctors tend to make what seems to them the more benevolent diagnostic choice.

"When the admitting diagnoses in general hospitals are reviewed, one rarely discovers a psychiatric diagnosis," says Dr. Poinard. His conclusion: Only when most health plans cover mental as well as organic disorders will the typical doctor be freed "from extraneous influences that determine the nature of his conclusion."

Where Rx's Are Taxed

There's a tiny increment to the cost of medical care that you and your patients may seldom think about: the sales tax on prescriptions. They aren't taxed in every one of the



ELORINE CHLORIDE^{*} REDUCES GASTRIC SECRETION AND G-I. MOTILITY

Lilly
QUALITY / RESEARCH / INTEGRITY

Especially valuable in the management of peptic ulcer patients

The selective anticholinergic action of 'Elorine Chloride' has been shown to produce a "pronounced and significant" decrease in mean gastric volume, free and total acid, and pepsin output.¹ It also effectively reduces hypermotility of the gastro-intestinal tract (except the esophagus). Other conditions in which 'Elorine Chloride' is valuable include functional digestive disorders, acute pancreati-

tis, diverticulitis, pylorospasm, and excessive sweating.

Dosage should be tailored to patient tolerance. In peptic ulcer, the average adult dose ranges from 100 to 250 mg. three or four times daily. 'Elorine Chloride' is available in pulvules of 50 and 100 mg.

^{**}'Elorine Chloride' (Tricyclamol Chloride, Lilly)

¹ Sun, D. C. H., and Shay, H.: A.M.A. Arch. Int. Med., 97:442, 1956.

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PREVENT both cause and fear of ANGINA ATTACKS

*"In diagnosis and treatment [of cardiovascular diseases]
...the physician must deal with both the emotional and
physical components of the problem simultaneously."*

*The addition of Miltown to PETN, as in Miltrate,
"...appears to be more effective than [PETN] alone in the
control of coronary insufficiency and angina pectoris."*

1. Friedlander, H. S.: The role of nitrazin in cardiology. *Am. J. Card.* 1:295, March 1958.

2. Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. *Angiology* 8:504, Dec. 1957.

NEW
dovetailed
therapy
combines
in ONE tablet



Miltrate^{*}

proven safety for long-term use

prolonged relief from
 anxiety and tension with

MILTOWN[®] + PETN

The original meprobamate,
 discovered and introduced
 by Wallace Laboratories

sustained coronary
 vasodilation with

pentaerythritol tetranitrate
 a leading,
 long-acting nitrate

Miltrate is recommended for prevention of angina attacks, not for relief of acute attacks.


Supplied: Bottles of 50 tablets.

Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.

Usual dosage: 1 or 2 tablets q.i.d. before meals and at bedtime.

Dosage should be individualized.

For clinical supply and literature, write Dept. 3C

 **WALLACE LABORATORIES, New Brunswick, N. J.**

CNL-7189

^{*}TRADE-MARK

thirty-three states that levy sales taxes. According to the Tax Foundation, nine (Connecticut, Florida, Illinois, Maine, Maryland, North Carolina, North Dakota, Pennsylvania, and Rhode Island) exempt prescriptions entirely. One (Michigan) taxes the Rx at half the regular rate. But your prescriptions are taxed like any other article of retail trade if you live in Alabama, Arizona, Arkansas, California, Colorado, Georgia, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Washington, West Virginia, Wyoming, or the District of Columbia.

Young Doctors Termed Our Best Ambassadors

"Go abroad, young doctor," advises the president of the American College of Physicians. Dr. Richard A. Kern believes that a short foreign apprenticeship should be a standard part of medical training, since it broadens the physician's medical and cultural horizons. He also argues that such apprenticeships are in the national interest.

"Medicine speaks a universal language, and the physician is in consequence our best ambassador of goodwill," he explains. "Our churches have found the medical missionary is the best spearhead."

So he urges the Government to establish "a special office in the State Department that would be able to tell us when there's a spot open for a doctor in Venezuela or in Iran."

Drug Men See Recent Case As Liability Threat

The trend toward higher malpractice awards results from "a new social philosophy . . . that everyone is entitled to ample compensation for any physical injury he may suffer," says an informed lawyer. And the way juries are applying this new "philosophy" seems to be affecting liability coverage in many fields. The latest group to feel its effect: drug manufacturers.

Spokesmen for the industry say their liability coverage is in danger because of one recent court case: A California jury ordered Cutter Laboratories to pay \$147,300 after two children contracted polio—allegedly from live Cutter vaccine. What particularly worries the drug men is that the jury awarded damages *even though it found the firm not guilty of negligence.*

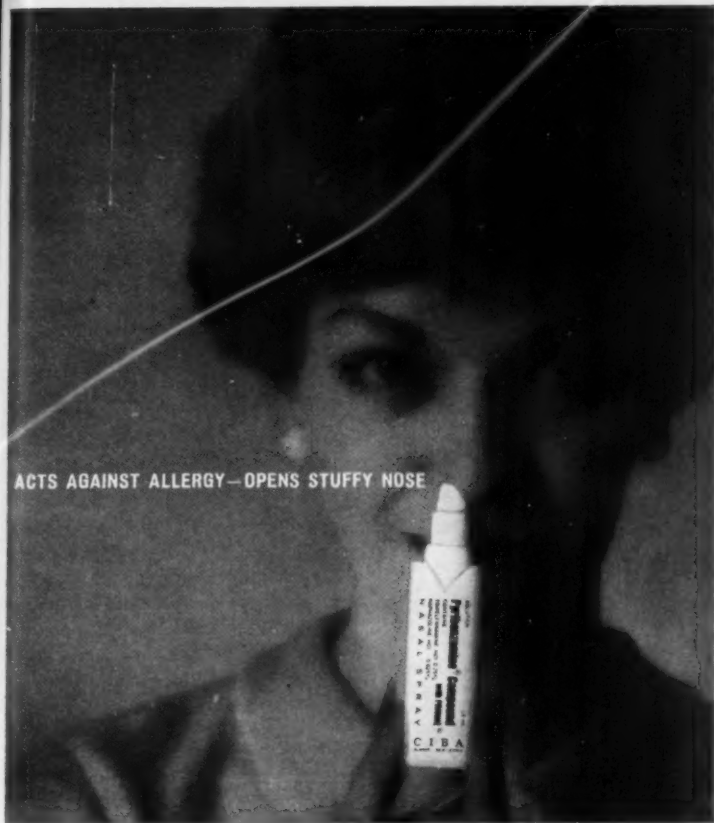
Thus the case appears to have been decided on a principle somewhat akin to "res ipsa loquitur." As one drug-industry attorney, Wallace E. Sedgwick, explains it: The jury decision means there's an "implied warranty" in drug manufac-

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ACTS AGAINST ALLERGY—OPENS STUFFY NOSE

**New double-action
formula in one
convenient spray**

Pyribenzamine® Compound with Privine® NASAL SPRAY

One spray quickly brings welcome relief from troublesome hay fever symptoms—and lets the patient breathe freely again.

Allergic irritation and sneezing stopped by direct antihistaminic action of Pyribenzamine on nasal mucosa and sinuses.

Runny nose and nasal congestion relieved by the prompt vasoconstricting effect of Privine

PYRIBENZAMINE® COMPOUND with PRIVINE®
(tripelennamine hydrochloride and naphazoline hydrochloride CIBA)

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MEDICAL ECONOMICS • JULY 7, 1958 47

IN
VAGINITIS
94%
EFFECTIVE*

*Against the
WHOLE
Vaginitis Spectrum*



MILIBIS®
Vaginal
Suppositories

A clinical study including 510 patients with vaginitis of trichomonal, monilial or mixed bacterial (nongonococcus) origin showed that Milibis Vaginal Suppositories promptly stopped leukorrhea and promoted restoration of normal vaginal flora in 94% of the cases.

*Shenophy, J.F.: *New York Jour. Med.*, 55:1335, May 1, 1955.

Milibis Vaginal Suppositories are well tolerated, easy to use (1 every other night), well accepted by patients.



Boxes of 10 with
plastic applicator.

Sanitary • Assures correct placement.

Winthrop LABORATORIES
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Milibis (brand of glycolborsol), trademark reg. U.S. Pat. Off.

NEWS

ture—in other words, when a drug causes harm, its maker is liable whether or not negligence was a factor.

The decision is being appealed. But Sedgwick says the Cutter case has already led some insurers to re-examine drug firms as liability risks: A top insurance executive "has expressed doubt to me personally that his company can continue to insure pharmaceutical manufacturers if a threat toward absolute warranty liability develops."

Anti-G.P. Tax Ruling

The Internal Revenue Service appears to have chosen sides in the specialist-G.P. controversy. According to a new ruling, a cardiac patient may deduct as a medical expense the cost of a special reclining chair—"if," says the Service, "it can be substantiated that the chair was prescribed by a cardiac specialist."

New Law Makes Hospital Staff Rules Binding

Most doctors couldn't get away with bucking their hospital's rules. But because of fuzzy wording in an old law, a few Michigan doctors could. That's why Michigan's medical and hospital leaders gave a sigh of relief some weeks ago when their State Legislature rewrote this old law. Here are the details:

Seven hospitals were built under Michigan's 1913 County Hospital

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tablets • suppositories

CONTACT

LAXATIVE

acts directly on colonic mucosa
does not depend on systemic absorption

chemically different • pharmacologically unique
clinically distinctive

• prompt and predictable action

• Tablets: work overnight without disturbing sleep; taken before breakfast, act within six hours

• Suppositories: produce evacuation in 15 to 60 minutes

• acts directly on colonic mucosa
• virtually no contraindications
• very well tolerated

dosage: Tablets: One to 3 (usually 2) at bedtime for bowel movement the following morning, or ½ hour before breakfast for a movement within six hours.

Suppositories: One at time bowel movement is required.

supplied: DULCOLAX® (brand of bisacodyl). Yellow enteric-coated tablets of 5 mg. in boxes of 6 and bottles of 100. Suppositories of 10 mg. in boxes of 6. Under license from C. H. Boehringer Sohn, Ingelheim.

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'DIURIL'

CHLOROTHIAZIDE

BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp.
9:58 (January) 1958.

"On chlorothiazide the response was striking with . . . improvement in cardiac status and loss of toxic symptomatology. . . . One of the most important effects of the potent oral diuretic was the smooth continuous diuresis. There was less fluctuation in the weight . . . marked diminution in the number of acute episodes of congestive heart failure such as paroxysmal dyspnea and pulmonary edema. . . . [DIURIL] appeared as potent a diuretic as parenteral mercurials and indeed in some patients it was effective when parenteral mercurials failed. . . . We have encountered no patient who once responsive to chlorothiazide later developed resistance to it."

DOSAGE: one or two 500 mg. tablets DIURIL once or twice a day.

SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide);
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ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

MEDICAL ECONOMICS · JULY 7, 1958 51

HAY FEVER
SUFFERERS *get greater relief* with*

Novahistine LP[†]

than with antihistamines alone

*greater relief... because a distinctly additive action is obtained by combining a sympathomimetic with an antihistaminic drug.

continuous-acting tablets... for continuous relief

EACH LP TABLET CONTAINS:

Phenylephrine hydrochloride.... 20 mg. : Supplied in
 Chlorphenpyridamine maleate . 4 mg. : bottles of 50 tablets.

*For day-long or night-long relief, 1 dose of 2 tablets
 (1 tablet for mild cases and children).* †Trademark



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Law. They got along without legal difficulties until 1951. Then the Grand View (Gogebic County) Hospital withdrew one doctor's privileges, and he went to court to get them back.

The doctor was charged with six violations of staff rules, including failure to keep proper medical records. His attorneys maintained the rules were set up in violation of the state law, which read in part: "The physician employed by [a] patient shall have exclusive charge of the care and treatment of such patient."

Another part of the law said: "No discrimination shall be made against practitioners of any [le-

gally recognized] school of medicine. . . and all such practitioners shall have equal privileges." This, said the attorneys, forbade the county hospital to withdraw any physician's privileges. And Michigan's courts had to agree.

Ever since, Michigan's medical and hospital leaders have been trying to get the law rewritten. Recently they succeeded. The State Legislature deleted the sentences quoted above and added the following in their place:

The hospital board, "with the advice of the medical staff," may set up "regulations and policies. . . governing the operation of the hospital and the professional work,



"finger-itis"
yes, any rheumatic "itis" calls for
Sigmagen
colloidal-salicylate compound

Schering

SG-J-298

surgical privileges, . . . and maintenance of records of and by the physicians and surgeons." The hospital board also "may deny hospital privileges and facilities to any physician or surgeon who violates" its regulations.

The new law still grants any licensed physician the privilege to practice in the hospital and to take charge of patients who employ him—but with this clear proviso: "subject always to such rules and regulations as shall be established by the board of trustees."

'Don't Scoff at That \$50 Dividend Exclusion'

You undoubtedly know that you don't have to pay taxes on your first \$50 of dividend income during the year. And that your wife gets the same tax break. But, like thousands of other stockholders, do you feel it isn't worth the bother of transferring stock to your wife's name "just to save \$50"? Then consider what you'd have to invest to get a \$50 return *after taxes*:

Suppose you have an income of \$20,000, including dividends from stock that pays 5 per cent. If you transferred \$1,000 of your holdings to your wife, she'd get a tax-free \$50 in dividends. That \$50 represents what would be left after taxes on \$80 in dividends from stock in *your* name, The J.K. Lasser Tax Report points out. And \$80

in dividends requires an investment of \$1,600 at 5 per cent.

So using your wife's apparently small dividend exclusion is a pretty big thing after all.

Texans Move Slowly to Approve Cancer Film

Voluntary health agencies used to be accused of not working closely enough with organized medicine. But recent experience in Texas indicates that there may now be such a thing as too much concern for cooperation.

Texas doctors, who are proud of the guidance they give their branch of the American Cancer Society, make up a majority on all its important committees in the state. County chapters are formed only with the aid of local doctors. Cancer health-education material is routinely cleared through medical channels before being released to the lay public.

Only trouble: Such routine clearance apparently takes a lot of time in the gigantic Lone Star State. For quite a while now, the Cancer Society has been circulating an educational film called "Breast Self-Examination." The film was passed, as usual, by the A.M.A. and by the appropriate specialty group. But Texas-wide distribution took a long time to achieve. Each county society had to vote approval before laymen of

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"Remember him? Used to need injections every week. Since he takes Neohydrin he only comes once a month for check-ups."

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TABLET

NEOHYDRIN®

Prescribe NEOHYDRIN (brand of chlormerodrin) in bottles of 50 tablets.
There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea,
equivalent to 10 mg. of non-ionic mercury,
in each tablet.

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when your
overweight
patient
is tense,
anxious and
irritable

One 'Dexamyl' *Spansule* capsule, taken in the morning, will:

- provide daylong control of appetite
- calm tension, anxiety and irritability, producing an attitude of cheerful optimism


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Dexedrine* (dextro-amphetamine sulfate, S.K.F.)
and amobarbital

sustained release
capsules, S.K.F.

2 dosage strengths: No. 1 and No. 2

*T.M. Reg. U.S. Pat. Off.



**when your
overweight
patient
is listless,
apathetic and
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One 'Dexedrine' *Spansule* capsule, taken in the morning, will:

- provide daylong control of appetite
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sulfate, S.K.F.

sustained release
capsules, S.K.F.

3 dosage strengths: 5 mg. (new), 10 mg. and 15 mg.

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in sustained release oral medication

the county could see the film. It was two years before the last county society gave its okay.

M.D.s Urged Not to Hide Their Need for Money

Physicians ought to be "moving the question of their financial reward into the arena of open discussion," says the former science editor of International News Service. H. Jack Geiger, now a medical student at Western Reserve, points out that "the physician's interest in making money is a perfectly legitimate private aim—but because it touches on health, a matter of public concern, it is a private aim of public consequence."

So long as both the costs and quality of medical care remain social problems, both must ultimately be subject to some degree of social regulation, Mr. Geiger thinks. He argues that by refusing to admit that their incomes are a matter of public concern—by pretending, in fact, they're not interested in money—U.S. doctors are damaging their case in the eyes of the public. This is "nowhere . . . better demonstrated than in the recurring debate over socialized, government-operated medicine," he writes in *The Scientific Monthly*.

"There are, I believe, many sound reasons for opposing most such schemes," says Geiger. But he believes the nation's physicians

wrong-headed in refusing to admit that at least one reason for their opposition is "fear of the consequences to physicians' incomes and preferred working arrangements." In any event, he insists, this fact couldn't escape anyone "who has [noticed] the contrast between physicians' public discussions of the issue and their discussions with each other."

Canada Called Too Rich In Medical Schools

U.S. doctors are constantly being warned that the supply of medical graduates is dragging behind our soaring population figures. But our neighbor to the north evidently has just the opposite problem: One Canadian physician has complained that his country's medical schools are turning out too many new doctors.

To support the charge, Dr. R.R. Struthers of Toronto compares the number of Canadian medical students (4,000 in twelve schools for a population of 16 million) with the number in this country (32,000 in eighty-six schools for 180 million people). In order to equal Canada's student-to-population ratio, he points out, the U.S. would need to provide facilities for an extra 13,000 students.

Why is Canada's wealth in this respect nearly as dangerous as our poverty? For one thing, says Dr.

Documentary Case History . . .

Hypertension controlled for four years with **Serpasil**[®]

(reserpine CIBA)



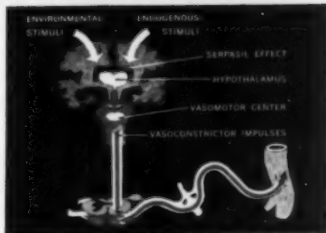
K. C., a 67-year-old retired shirt manufacturer, had a 16-year history of hypertension, was troubled by recurrent dizzy spells and headaches. "I'd get several attacks a day. . . . Usually I'd go into the bedroom and lie down." Serpasil therapy was started four years ago, effecting a gradual reduction of the patient's initial blood pressure of 220/120 mm. to the present 140/80. Now well and asymptomatic, ". . . I'm able to go to matinees and see some of the TV shows."

SUPPLIED: TABLETS, 4 mg. (scored), 2 mg. (scored), 1 mg. (scored), 0.25 mg. (scored) and 0.1 mg. ELIXIRS, 1 mg. and 0.2 mg. Serpasil per 4-ml. teaspoon. PARENTERAL SOLUTION: Ampuls, 2 ml., 2.5 mg. Serpasil per ml. Multiple-dose Vials, 10 ml., 2.5 mg. Serpasil per ml.



Hypertension controlled through SYMPATHETIC REGULATION

Serpasil shields the psychic and somatic reaction centers from emotional and environmental stress stimuli, thereby inhibiting the discharge of vasoconstrictive impulses through the sympathetic nerves.



Adapted from Moyer, J. H., Dennis, E., and Ford, R.: Arch. Int. Med. 96:530 (Oct.) 1955.

C I B A SUMMIT, N. J.

8/3536MX

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Struthers, his country's schools are hard-pressed to find "adequate numbers of adequately prepared students." Then, too, young doctors are being turned out at twice the rate needed to maintain the present ratio of physicians to population; so there's a possibility of "cutthroat competition for patients." And he fears that this might lead to lower standards of medical ethics. "It is time to call a halt to . . . expansion," he warns.

But there's a ray of light for U.S. medicine in the doctor's somber warning: Because the Canadian field is overcrowded, he points out, some 250 of each year's crop of new M.D.s come to the States.

Doctors Get New Ally Against Auto Mishaps

In their campaign for safer driving, physicians have enlisted a formidable new ally: Emily Post. The nation's arbiter of etiquette has advised her readers to "be rude for safety's sake."

Don't help a woman into a car, she says, and then walk through traffic to get in yourself from the other side. It's both good sense and good manners for a gentlemen to crawl in from the sidewalk and let the lady follow him, according to Mrs. Post.

Moreover, she adds, you needn't light a woman's cigarette while you're behind the wheel. You

won't be considered a boor if you even ask the lady to light *your* cigarette for you.

Shattered? Wait till you hear this one: Mrs. Post suggests it's now acceptable etiquette, if your companion insists on chattering while you're trying to concentrate on traffic, to ask her to shut up.

Medicine Men Vanishing

Modern medical science seems to be moving forward in some unexpected quarters. According to one report, it's even weaning the American Indian away from his traditional medicine man. "Medicine men are fast going out of business," Paul Jones, chairman of the Navaho Tribal Council, has told a Senate committee. "Their patients have had a taste of modern medicine and liked it," he explains.

For Thirsty Freudians

The vulgarization of psychiatric theory has hit what onlooking physicians hope is rock bottom, with the recent appearance in New York's Greenwich Village of a drink emporium called "The Couch." Waiters wear an approximation of doctors' garb. And they serve drinks with names like "Dr. Freud," "Complex," and "Psychic Masochist." The drink called "Dr. Freud" is a mixture of rum, lemon peel, and V-8 juice.

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In Peptic Ulcer. ONE, All-Purpose Formula

ALUDROX SA benefits the peptic-ulcer patient by providing complete medical management in one preparation. It relieves his pain, reduces his acid secretion, calms his emotional distress, promotes ulcer healing.

Ambutonium bromide, an important *new* anticholinergic, incorporated into the time-proved formula of ALUDROX, reduces gastric secretion and motility without significant side-effects or toxicity.

For long- or short-term management—*anticholinergic, sedative, antacid, demulcent, anticonstipant* . . .



SUSPENSION

TABLETS

ALUDROX[®] SA^{*}

Aluminum Hydroxide Gel with Magnesium Hydroxide,
Ambutonium Bromide, and Butabarbital, Wyeth



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^{*}Sedative and anticholinergic

MEDICAL ECONOMICS • JULY 7, 1958 61

when you prescribe protection...



Consider her comfort. Women naturally welcome the comfort of the RAMSES® Diaphragm, with its cushion-soft rim, flexible in all planes to adjust to vaginal muscular action. The RAMSES dome, velvet smooth and thin, yet strong and durable, fits closely over the cervix to form a barrier against sperm.

Consider the convenience. The specially designed RAMSES Introducer safely and accurately guides the diaphragm into place. RAMSES Vaginal Jelly,* applied in the two folds of the dome, remains in place during insertion.

Consider the strength of motivation. Psychologic motivation has been found to be increasingly important to the success of contraceptive measures. So-called "method failures" may actually be "patient failures," the result of patients receiving inadequate information, underestimating the importance of the prescribed routine, or not sufficiently desirous of remaining nonpregnant. Properly used, RAMSES Diaphragm and Jelly reduce the likelihood of conception by at least 98%.¹

After fitting the diaphragm, prescribe the RAMSES "TUK-A-WAY"® Kit #701—the complete unit, containing diaphragm, introducer and jelly in attractive zippered bag. Diaphragm sizes 50 to 95 mm. Jelly in 3 and 5 oz. tubes at all pharmacies.

1. Tietze, C.: Proceedings, Third International Conference Planned Parenthood, 1953.

*Active agent, dodecaethyleneglycol monolaurate 5% in a base of long-acting barrier effectiveness

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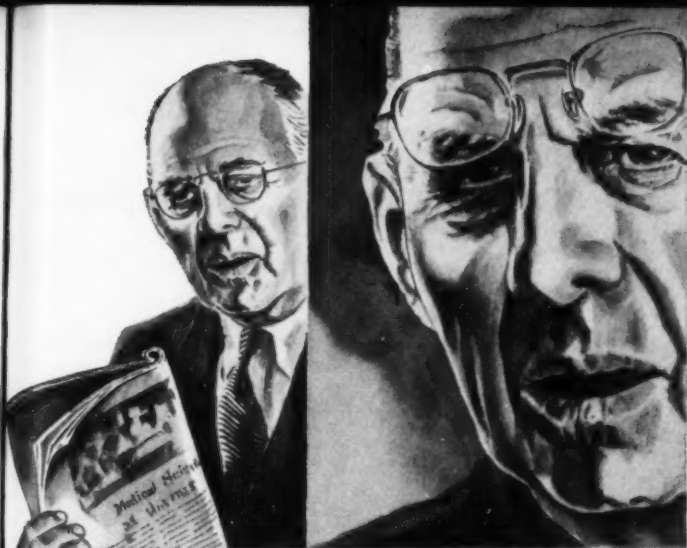
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"Doctors can't help shingles?"

Physicians who have used PROTAMIDE extensively deplore such statements as unfortunate when they appear in the lay press. They

have repeatedly observed in their practice quick relief of pain,

even in severe cases, shortened duration of lesions, and greatly lowered incidence of postherpetic neuralgia when

PROTAMIDE was started promptly. A folio of reprints is available. These papers report on zoster in the elderly—

the severely painful cases—patients with extensive lesions. PROTAMIDE users know "shingles" can be helped.



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Available: Boxes of 10 ampuls—prescription pharmacies.



running noses ...



and other hay fever symptoms

TRIAMINIC stops rhinorrhea, congestion, other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are usually best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at congestion of the nasal mucosa. TRIAMINIC provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 more hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. tsp. is the equivalent of $\frac{1}{4}$ TRIAMINIC Tablet or $\frac{1}{2}$ TRIAMINIC Juvelet.

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...because it tastes so
much richer than ordinary
nonfat milk

**Specify "self-enriched"
Carnation Instant
to help patients "stay
with" low-fat diet**

**25% more protein, too
— and it's so easy!**

The physician simply specifies one extra tablespoon of crystal-form Carnation Instant per glass (or $\frac{1}{2}$ cup extra Magic Crystals per quart) over package directions.

This provides a 25% increase in nonfat milk solids with no increase in liquid bulk. Each quart provides 60% of the daily protein requirement* of men—an important factor when other major protein sources are severely restricted, as in low-fat diet.

Most people enjoy "self-enriched" Carnation Instant Nonfat Dry Milk because the flavor is naturally fresh and far richer than ordinary nonfat milk.

Thus, Carnation Instant, "self-enriched," helps patients stay with low-fat diet two ways: because it is more delicious for drinking; because it provides extra protein to help maintain stamina and well-being.

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TASHAN®
TO RELIEVE

- simple eczema
- dry, scaly skin
- detergent rash
- intertrigo, chapping
- contact dermatitis
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These and many other superficial skin complaints usually respond dramatically to Tashan Cream Roche. Antipruritic, soothing and healing, Tashan contains vitamins A, D, E and *d*-panthenol, in a cosmetically pleasing, virtually non-sensitizing, water-soluble base.



In 1-oz tubes
and 1-lb jars.

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TO HELP CORRECT CONSTIPATION *Antacid • Laxative • Lubricant*

Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity.

The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



SUPPLIED:
Bottles of 8 oz.,
1 pint, 1 quart.

THE CHAS. H. PHILLIPS CO. DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

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now

*in a new dosage form ...
to simplify treatment
of anxiety states*

Trilafon Repetabs

perphenazine



Availability of TRILAFON REPETABS now makes it easier to achieve smooth and sustained control in anxious, tense or psychoneurotic patients. Each 8 mg. REPETAB provides a full 4 mg. of TRILAFON for rapid onset of relief *plus* a second, timed 4 mg. dose for prolonged all-day benefits.

No need for the agitated patient to be concerned about complicated dosage directions. Just one TRILAFON REPETAB in the morning and another in the evening will carry the average patient through a full day and night.

TRILAFON® REPETABS®—8 mg., bottles of 30 and 100.

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now—*for anxiety, agitation,
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*a form to fit every patient
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Trilafon[®]

perphenazine

full-range tranquilizer, most potent antiemetic

BENEFITS NOW EXTENDED TO MORE PATIENTS

TRILAFON REPETABS,[®] 4 mg. of TRILAFON in the outer layer and 4 mg. in the timed-action inner layer. Bottles of 30 and 100.

TRILAFON INJECTION, 5 mg./cc., ampul of 1 cc., boxes of 6 and 100.

TRILAFON SYRUP, 2 mg./tsp. (5 cc.), 4 oz. bottle.

TRILAFON Tablets—grey tablets of 2 mg. (black seal), 4 mg. (green seal), 8 mg. (blue seal), bottles of 50 and 500; 16 mg. (red seal), for hospital use, bottle of 500.

For details on indications, dosage, side effects, precautions and contraindications consult Schering literature.



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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JULY 7, 1958

How to FIGHT the FORAND Bill

If doctors want to block Federal medicine for the aged, this M.D. warns, they've got to switch Blue Cross-Blue Shield to a paid-up-at-65 basis. Here's his call to action

By Alexander A. Jaworski, M.D.

"I find, as usual, that the A.M.A. is opposing health legislation to solve the medical problems of older people but offering nothing as an alternative."

So says Representative Aimé J. Forand (D., R.I.), in commenting on the Association's stepped-up campaign to kill the bill that bears his name. As you know, that bill has been awaiting House action. If passed, it would increase Social Security payroll tax rates by 22 per cent in order to provide Government-paid hospital and medical care for the elderly. And many doctors see it as an enter-

THE AUTHOR is chairman of the medical economics committee of the Pawtucket (R.I.) Medical Society.

HOW TO FIGHT THE FORAND BILL

ing wedge for Federal control of medicine.

I agree with my colleagues that the Forand bill must be fought to the death. But I agree with Mr. Forand that negative opposition isn't enough. I think it's up to us doctors to offer something as an alternative.

It's Up to Doctors

Right now, there are 14,000,000 people over 65 in the U.S. By 1975, the total will probably reach 21,000,000. Their medical expenses are likely to be relatively high, their incomes relatively low. And the problem of providing for their health needs *should be solved by private medicine.*

This much seems clear: Unless the nation's doctors find a way to do it voluntarily, the Government will do it by compulsion.

A start toward voluntary coverage of the aged has already been made. Most of the Blue plans now permit people over 65 to participate, either as group members or as individuals. Many commercial companies allow retiring employees to convert their group policies to individual contracts. And some companies will even sell new policies to people as old as 75 or 85.

All well and good for those who can afford to pay the premiums after they've retired. But many, many of our senior citizens can't. What they need is some kind of paid-up health coverage.

I maintain that the doctors' plans should—and can—give them just that. If Blue Shield and Blue Cross act fast, they'll take the steam out of the Forand bill.

I see no reason why all existing Blue plan contracts shouldn't be replaced by new contracts offering paid-up-at-age-65 health coverage. Naturally, such coverage would cost the subscriber more during his working years. But he'd get continuing benefits without being subjected to the burden of continuing premiums after his retirement.

Are Oldsters Insurable?

Could such a program really work? Most insurance people seem to think not. They fear that the medical bills of the elderly might be too high and unpredictable to be insured against.

But two of the largest insurance companies in the country, the Metropolitan and the Prudential, apparently disagree. They now issue paid-up-at-65

health policies. And they believe the idea is actuarially sound.

If the Metropolitan and the Prudential aren't afraid of the big, bad actuarial wolf, why should the doctors' plans be?

Many Problems

Sure, there are many problems to be solved before Blue Cross and Blue Shield can be put on a paid-up basis. We've solved tough problems before. We can do it again.

I don't pretend to have answers to all the questions you might ask about the program I've been suggesting. But I think I can indicate the direction in which some of the answers lie. For example:

How much would the paid-up feature add to the cost of the Blue contracts?

My guess is that a 10 per cent increase in the premiums for all subscribers might be enough to finance paid-up benefits for the elderly. That's just a rough approximation, based on the fact that about one-tenth of the population are over 65.

The actual rate increase for a given plan would depend on its own experience. And if initial rates proved to be wrong—either

too high or too low—they could always be changed. (Both the Metropolitan and the Prudential have reserved the right to change the schedule of premiums for their paid-up policies.)

If costs turned out to be too high, perhaps a co-insurance arrangement could reduce them. The oldsters would then have to pay a small part of their own medical expenses. Or maybe a "work clause" like the one in the Social Security set-up would be effective. Under such a clause, the subscriber would be eligible for paid-up benefits only if he were earning less than, say, \$80 a month.

MORE ►



HOW TO FIGHT THE FORAND BILL

Neither of the above compromises would be ideal. But they'd cut the cost of the program, if necessary. And either of them would be better for the senior citizen than no health coverage at all.

Rough on Young People

Would younger people object to the higher rates?

At first, some would be sure to. If a paid-up plan went into effect tomorrow, for instance, a man of 60 would have to pay a steeper premium for only five years in order to get lifetime coverage. The 30-year-old subscriber, who'd have thirty-five years of payment ahead of him, might therefore feel he was getting a raw deal.

The Metropolitan and Prudential policies solve this problem simply: Their rates are lower for young subscribers. For example, one Prudential contract costs \$88.76 a year until age 65 if you buy it when you're 35. But the same coverage bought at age 55 would set you back \$194.94 a year.

The Blue plans can't do this sort of thing if they want to stick to the community-rate principle of charging the same premium

for everyone. (And they do want to stick to it, I'm sure.) But there's another possible answer: The scope of paid-up benefits might be based on length of participation in the plan.

For example, a man who has had paid-up-at-65 coverage for over ten years might be entitled to full service benefits after 65. Those with fewer years in the plan would get correspondingly less, according to a fixed schedule of indemnities.

Blues Can't Do It Free

How would the program I'm suggesting help those who are already over 65?

Representative Forand's bill would simply give such persons free care. The multi-billion-dollar Social Security reserve fund would pick up the tab. Obviously, the doctors' plans can do no such thing.

But the current elderly *could* be allowed to join the new program on a premium-paying basis. And they could become eligible for paid-up benefits after a certain number of years. After all, time would soon solve this problem, once the paid-up program got under way.

All the above questions boil

down to one: How can we balance the interests of the younger and older age groups in a paid-up contract that's actuarially sound? But this puzzler is no more difficult than the basic problem faced by Blue Cross and Blue Shield in their early days.

Not many years ago, the insurance industry thought that the very concept of community-rate health insurance violated "the unalterable principles of insurance."

It was the Blue plans that proved them wrong. And we can do it again!

None of us deny that the idea is pretty novel and that we'll need a lot of experimentation in order to find out whether it's truly feasible. But if it takes experimenting to defeat dangerous bills like Representative Forand's—well, let's experiment.

"The American physician has a golden opportunity to help make voluntary health insurance solve the problem of financing medical care," says Dr. George M. Wheatley, vice president of the Metropolitan Life Insurance Company. "The incentive is his freedom."

END

Sleep Spoiler

One wintry night at 2 A.M., a pediatrician I know received an urgent phone call. A frantic father urged him to come quickly to attend a desperately ill baby.

The doctor immediately took a cold shower to arouse himself, threw on his clothes, and sped through snow to the address, several miles away.

But when he arrived, repeated knocking and doorbell-ringing brought no response from the unlighted house. The doctor turned to leave for the hospital, where he assumed the anguished parents had taken the child.

As he did, the front door opened a crack. Through it came an exasperated whisper: "Don't make so much noise! The baby has gone back to sleep."

—JEANNE STEELE

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N. J.



Should You Base Fees on Ability To Pay?

*Most doctors still think so—and most patients
seem to approve—according to this new study*

By Wallace Croatman

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Is it still a good idea to vary your fees according to the patient's ability to pay? The answer is "Yes," according to a recent survey of doctors and patients conducted by the University of Chicago's National Opinion Research Center.

The study was made in cooperation with the Health Information Foundation. It included personal interviews with a nation-wide cross section of patients and their family physicians—about 3,000 persons in all. The full report on the survey will not be published until next year. But advance examination of the data points toward these conclusions about fees based on the patient's ability to pay:

¶ Despite all indications in recent years that the sliding scale is outmoded, more than three out of five family doctors still gear their fees to the patient's ability to pay.

¶ Most patients, too, seem to approve of the practice. And the ones most in favor of it are the ones who usually pay the highest fees under it.

¶ In evaluating patients' ability to pay, doctors tend to think that people are better off financially than they really are.

¶ Even so, most people have the resources to pay the resulting bills. They rarely have to borrow to pay a doctor.

The tables that follow sum up what doctors and patients say about fees in relation to ability to pay. The text points up the most significant findings.

"Do you charge all of your patients the same fee, regardless of their financial circumstances?" To this question, the doctors replied as follows:

Yes37%

No63

Thus the survey offers no evidence that sliding-scale

BASE FEES ON ABILITY TO PAY?

fees are going out of style. The proportion of doctors who consider the patient's financial situation is about the same as it was in a poll of family doctors conducted by this magazine four years earlier.

Sliding-scale fees are especially common among members of specialty societies, big-city practitioners, and those in the Far West. And there seems to be some connection between a physician's ability and his patients' ability to pay. At least, medical men rated "much better than most" by the surveyed patients are more likely to charge sliding-scale fees than "just-about-average" doctors.

The next question was aimed at the patients: "*Do you think a doctor should have the same fees for all, or should he charge people according to their income?*" The replies broke down this way:

<i>Same fees for all</i>	.....43%
<i>According to income</i>	..51
<i>Don't know</i>	.....6

Apparently there's a strong element of snob appeal in the public's attitude toward doctors' fees. At any rate, the more money a patient earns, the more

strongly he feels that people in his stratum *should* pay more for the medical services they get.

Now back to the doctors again. The N.O.R.C. asked them: "*Are your patients better off financially than the average in this area, or are they worse off than average?*" The doctors' replies:

<i>Better off</i>	.....25%
<i>About same</i>	.....63
<i>Worse off</i>	.....11
<i>Don't know</i>	.....1

In actual fact, there were about as many low-income as high-income patients in the surveyed sample. Thus it would appear that doctors tend to think their patients are better off financially than they really are—and that, if a doctor deviates from his usual charge, he's more likely to raise it than lower it.

What type of doctor is most likely to have a high proportion of "better-off" patients? According to the survey, he's a man 60 or over, netting \$20,000 or more, practicing in a large metropolitan area, with membership in a specialty society.

Finally, the surveyed patients were asked: "*If your family suddenly had to pay out a \$500*

medical bill, how would you manage?" Their replies:

Without much trouble . . 43%
Very difficult 40
Couldn't pay 17

When persons with below-\$2,000 incomes are ruled out, a majority of patients say they could pay a bill of this size without much difficulty. Four out of five persons in the over-\$7,500 category could pay such a bill without trouble. Moreover, the

great majority of patients—86 per cent—have never had to borrow to pay a doctor bill.

So, while the average doctor may not always judge his patients' ability to pay accurately, he's certainly not charging all the traffic will bear. And if he's "soaking the rich" or playing the part of a "medical Robin Hood" or doing some of the other things that critics of sliding-scale fees claim, the "rich" don't seem to mind.

END



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"Dear Madam: About your request for professional courtesies because your divorced husband is a physician . . ."



Your Handwriting Gives You Away

*It reveals whether you're warm or cold,
quick-witted or slow, a dreamer or a doer,
says Dr. W. M. Knowles (above). Want proof?
Here are his grapho-analyses of Drs. David B. Allman,
Leroy E. Burney, Morris Fishbein, Karl Menninger,
I. S. Ravdin, and Paul Dudley White*

Does your handwriting decidedly slant to the right? Then you're probably emotional and warmhearted. If, on the other hand, it's nearly vertical or left-slanting, you tend to be coldly scientific.

Do you make rounded loops at the top of letters like m and n? If so, you're a doctor who takes his time digging for facts. But if your handwriting shows needle-like points here, you're probably a quick thinker who grasps facts almost instantly.

Do you end words with long, flowing upstrokes? Then you may be a bit of a showman. If instead your handwriting looks close-knit or cramped, you're probably somewhat self-conscious.

The men who make these diagnoses call themselves grapho-analysts. One of them is W. M. Knowles, M.D., C.G.A. (for certified grapho-analyst). He uses the technique occasionally in his Dallas, Tex., medical practice—and more often to confound his local colleagues.

"Most doctors," he says, "won't believe that their handwriting reveals seventy-five or more mental and personal traits. It takes a demonstration to convince them."

Just for fun, MEDICAL ECONOMICS has arranged such a demonstration. Whether it convinces you or not, it will probably interest you. The idea interested six nationally known physicians enough to send along unidentified samples of their handwriting for Dr. Knowles to analyze.

You'll see those samples on the next few pages, along with Dr. Knowles' pungent character-comments. You'll also read some reactions from the participating M.D.s.

YOUR HANDWRITING GIVES YOU AWAY



DR. DAVID B. ALLMAN has just completed his term as President of the A.M.A. There was a time when he did 40 per cent of all the surgery done in Atlantic City, N.J. He started there in 1915, visited patients on foot until he'd saved up the \$500 it took then to buy a car, still has his original office furniture. Though known as an exceptionally forthright man, Dr. Allman had no comment to make on the following handwriting analysis (done "blind"). Which suggests there may be something to it. Read it and see for yourself.

HIS HANDWRITING:

I do agree that this analysis should be entertaining (and perhaps enlightening) for both me and many physicians who will see it in Medical Economics.

ANALYSIS OF HIS HANDWRITING: "You will allow your emotions and impulses to overrule your better judgment. You have a keen, quick, fact-gathering mind that analyzes your problems. You are rather frank and outspoken, argumentative but diplomatic. You are also rather exclusive in your choice of close friends; but you are very loyal to them. Being somewhat visionary, you are almost a day-dreamer. None the less, you are thrifty and persistent; you never give up on an undertaking. But why not take that CHIP off your shoulder?"



DR. LEROY E. BURNEY has been Surgeon General of the Public Health Service for the last two years. Before that, as a P.H.S. expert on local health services, he visited every state in line of duty. At the most recent annual assembly of the World Health Organization, Dr. Burney was named president. The following handwriting analysis was done, like all the others in this experiment, without any knowledge of whose handwriting was being analyzed. But Dr. Knowles' analysis had him "sized up pretty well," Dr. Burney said.

HIS HANDWRITING:

The selection by a young man or woman of the college to which he would like to go is both an important and a difficult task. The role of the parent in assisting in this choice is a delicate one but equally important.

ANALYSIS OF HIS HANDWRITING: "You probably swim, dance, or engage in athletic sports. At least your mind tells you that you would enjoy them. You are orderly, rhythmic, and take note of small details. You have a well-developed imagination, a visionary outlook with a definite, distant goal. A creative and intuitive mind should make you capable in many lines of cultural activities like music, art, or craftsmanship. You can say 'Yes' and 'No' and mean it. You are generous, very persistent, a bit sensitive. You read as you run and thereby miss some of the facts."

YOUR HANDWRITING GIVES YOU AWAY



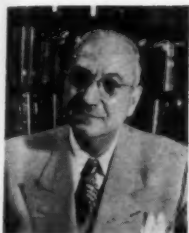
DR. MORRIS FISHBEIN, former editor of the *Journal A.M.A.* and sharp-tongued spokesman for organized medicine, doesn't think too much of graphology (see his handwriting sample). But grapho-analysis is different, according to its practitioners, in that it concentrates on characteristic strokes rather than on handwriting as a whole. After reading Dr. Knowles' analysis in this case (see below), Dr. Fishbein commented:

"I have no objections, but it certainly doesn't affect my thinking about grapho-analysis as a diagnostic tool."

HIS HANDWRITING:

Graphology is nothing resembling a science although handwriting can offer clues to the motor ability of the writer, his age, his education and training. Particularly difficult is analysis of the writing of a person whose system of penmanship was changed three times in eight years.

ANALYSIS OF HIS HANDWRITING: "You are no show-off. You go directly—almost abruptly—to the point. You are cool, calculating, and reserved, but broad-minded. Some experience has taught you to keep certain things to yourself. Let's call it professional deceit. Yours is a quick, orderly, analytical, and creative mind, with close attention to detail. But Brother or Sister, whichever you may be (for handwriting is sexless), grapho-analysis is not graphology, just like allopathy is not naturopathy. How about trying to delegate some authority to others?"



DR. KARL MENNINGER, senior psychiatrist of the Menninger Foundation, was once described in these pages as "restless and brilliant," unpredictably "serene or stormy." Which indicates the first three sentences of the grapho-analysis (below) are spectacularly wrong—and Karl Menninger has said so. Everything else he's labeled "right" except the next-to-last sentence ("Your mate tells you . . ."). Wrote Dr. Menninger: "She doesn't tell me. And why bring my wife into this? It's my handwriting, not hers."

HIS HANDWRITING:

I am not acquainted
with R. Knowles but I am
interested to learn that
he has made graphology
an avocation of his. I
have always believed that
it should have more usefulness

ANALYSIS OF HIS HANDWRITING: "People may cry all around you, but you shed never a tear. Your emotions simply do not show. You should be a good poker player. You are direct and straight to the point, exceptionally determined and persistent, and do not give up easily. You have a good many literary and cultural interests and a fine sense of form. You, too, are somewhat intuitive. Like music, don't you? Your mate tells you that you are independent and stubborn. And it seems that you are trying to control or even overcome a quick temper."

YOUR HANDWRITING GIVES YOU AWAY



DR. I. S. RAVDIN is chairman of the Board of Regents of the American College of Surgeons. As such, he's well-known to doctors throughout the country for his determined campaigns against fee-splitting and in behalf of better surgical training. These campaigns may well be traceable to the "superabundance of enthusiasm and determination" referred to in the handwriting analysis below. Dr. Ravdin preferred not to comment on this—nor on the F.D.R.-Billy Graham allusions in Dr. Knowles' very specific commentary.

HIS HANDWRITING:

A physician or surgeon heavily engaged in his own private practice may be an excellent teacher in a medical school insofar as time allows.

ANALYSIS OF HIS HANDWRITING: "You are a very kind, sympathetic, and generous person, but are not likely to tolerate any seeming imposition. You are positive and aggressive with a logical, fact-gathering, broad mind. You have a superabundance of enthusiasm and determination, which keeps you bouncing. You recognize your own capabilities; you should be a good diagnostician. You have many of the qualities of F.D.R. and Billy Graham. All you need to do is to let go on some of your suppressed emotions and relax."



DR. PAUL DUDLEY WHITE, the country's best-known cardiologist, has handwriting that apparently defies grapho-analysis. Certainly the conclusion that he "dislikes physical exercise" (see below) doesn't fit the man who helped make bicycle riding popular again. And from Dr. White himself: "I would say that this interpretation is perhaps 15 per cent correct and 85 per cent in error." But over-all, in this series of six interpretations done "blind," Grapho-analyst Knowles may have succeeded in reversing those percentages.

HIS HANDWRITING:

In the past the social aspects of the tuberculosis problem have tended to be overemphasized, thus engendering a passive approach to control in the face of poor living standards. But the basic fact to be kept in mind about tuberculosis is that it is a communicable disease, the attack on which should be of the dynamic character appropriate

ANALYSIS OF HIS HANDWRITING: "Your attitude is 'Think this over: Will it pay?' Coolheaded, calculating, and reserved, you don't let your emotions and impulses bother you. You arrive at conclusions after logical and analytical thinking. You like good clothes and good, rich food. You know how to wear colorful sport clothes without ostentation. If your feelings are hurt, they stay hurt. You are independent in thought and action. You use very little imagination, and you dislike physical exercise. No detours for you, and why are you so irritable?"

END

Today's Young Doctors Start Fast

The 'starvation period' you may have gone through is notably shorter now. In many cases, it's almost nonexistent, this new study shows

By Henry C. Black and Allison E. Skaggs



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EDITOR'S NOTE: You probably remember your first paying patient, your first month's earnings, your long, slow struggle to make your medical practice grow. Well, everything's moving faster now, according to the following report.

Compare it with your own recollections. Use it to measure your present practice growth. And note well this one point:

The authors have been studying and fostering the growth of medical practices ever since 1932, when they founded the professional management firm of PM—Battle Creek. (They now head Black & Skaggs Associates, which has PM affiliates in eleven states.) So the figures they have compiled show practice growth under favorable conditions.

Most of the young doctors they've surveyed are located in the Midwest, where medical earnings run higher than in other regions of the U.S. Then, too, all the surveyed doctors became PM clients within at least two or three months after starting practice—which sets them apart from other beginning doctors who don't have access to management help.

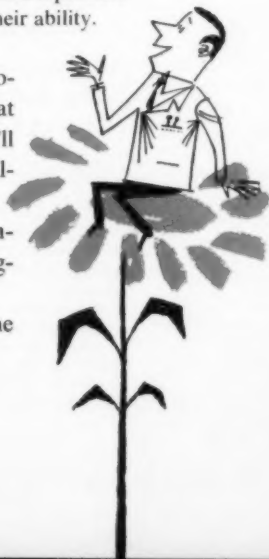
But if the first- and second-year economic experiences of these doctors cannot be called typical, they nevertheless demonstrate how fast a medical practice can grow under the right circumstances. Messrs. Black and Skaggs believe that most young doctors nowadays can match the earnings figures reported here if they pick a location, an office, and a practice set-up that permit them to make the most of their ability.

* * *

During his first few months of practice, today's doctor will almost certainly operate at a loss. If he's in independent practice, he'll have to borrow or use his savings. If he's salaried, his employer will cover the loss.

But the break-even point comes a lot sooner than it used to. The following facts and figures will show you what we mean.

These stem from a unique study of some



TODAY'S YOUNG DOCTORS START FAST

140 doctors who've entered solo practice since 1950. (The figures for a new member of an established group or partnership run slightly better.)

Most of the surveyed men are in one of the five largest fields of private practice: general practice, internal medicine, general surgery, obstetrics/gynecology, and pediatrics. So the following information applies chiefly—though by no means exclusively—to young doctors in those fields.

First, what are the lump-sum costs of getting started in practice today?

On the average, the surveyed physicians spent some \$3,880 on the initial furnishings and equipment for their offices. A few spent \$6,000 or more, while one G.P. managed with an initial investment of only \$1,000.

Next, what about earnings and expenses over the first twelve months? Let's start with a few first-year averages from the survey:*

Collections	\$15,717	
Professional expenses	6,714	
Net income	\$ 9,003	
Living expenses	\$6,200	
Life insurance premiums	600	
Income taxes	856	7,656
Net gain	\$ 1,347	

*Collections include occasional income from part-time salaried work, as well as all money collected for treating private patients. Professional expenses include office salaries; rent; drugs and supplies; depreciation on professional furnishings and equipment; business insurance, taxes, and interest; convention costs; medical society dues; medical journals; telephone; and professional car expenses. Net income is of course computed by subtracting professional expenses from collections.

Living expenses, as defined for the study, include all personal expenses except life insurance premiums and income taxes, which are listed separately. As for the net gain figure, it's reached by deducting the sum of the doctor's living expenses, life insurance, and income tax payments from his net income.

Here, next, are the highest and the lowest individual figures reported by the surveyed doctors for the same first-year items:

	High	Low
Collections	\$38,357	\$8,200
Professional expenses	14,157	3,636
Net income	26,994	3,280
Living expenses	9,628	3,747
Life insurance premiums	1,272	52
Income taxes	5,620	122
Net gain	12,080	-1,531

Net gain doesn't necessarily represent money in the bank. It may be used to repay loans, buy additional equipment, etc. But many management men consider it the most significant figure of all, since it sums up the doctor's progress in a way that collection or net income figures alone can't do.

Of course, since the doctor's net gain is partially determined by his *personal* living expenses, net gain figures aren't too useful for *professional* comparisons. So in order to compare the records of men in the five largest fields, let's stick to the net income statistics. Here are average net incomes for the first full year of practice:

General surgery	\$11,587
General practice	10,133
OB/Gyn.	9,352
Pediatrics	7,562
Internal medicine	6,989

It's understandable that the beginning G.P. should do better than men who are dependent on referrals. The surgeon's top place on the list is harder to explain. He's in a field that seems to be slightly overcrowded; and he often has to compete with surgically minded G.P.s as well as

TODAY'S YOUNG DOCTORS START FAST

board men. The answer may lie in the fact that he does collect sizable fees for major procedures.

Second-Year Progress

During the second twelve months of practice, nearly all the surveyed physicians registered substantial gains all along the line. The second-year averages:

Collections	\$26,073
Professional expenses	9,844
Net income	\$16,229
Living expenses	\$7,642
Life insurance premiums	879
Income taxes	2,881
	11,402
Net gain	\$ 4,827

And here are the second-year highs and lows:

	High	Low
Collections	\$51,368	\$14,972
Professional expenses	13,726	5,265
Net income	38,442	8,775
Living expenses	10,774	4,022
Life insurance premiums	2,800	120
Income taxes	10,398	1,360
Net gain	18,005	98

When ranked by average net income, the five largest fields line up in the same order as for the first year of practice. The second-year figures:

General surgery	\$20,496
General practice	17,531
OB/Gyn.	16,954
Pediatrics	15,175
Internal medicine	12,443

It's interesting to compare the above rankings with the latest income rankings for doctors of all ages, as indicated by MEDICAL ECONOMICS' 8th Quadrennial Survey. As far as the five largest fields are concerned, that survey showed that OB/Gyn. men had the highest median net incomes. They were followed by men in general surgery, pediatrics, general practice, and internal medicine, respectively.

Slow Start in OB

So it seems that the OB/Gyn. man has a long, slow pull to attain his maximum earning level, while the general practitioner gets off to a fast start but reaches his peak sooner.

The G.P.'s fast start probably explains the new survey finding that small-town doctors have the highest average



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"I had mine done right after I was born."

TODAY'S YOUNG DOCTORS START FAST

net income for the first year. Here are first-year net income averages for M.D.s in different-size communities:

Large (over 250,000)	\$ 9,693
Medium (25,000-250,000)	10,218
Small (under 25,000)	10,886

After twelve months, specialty practices in some of the larger cities apparently gather momentum. Average net income figures in the second year of practice are as follows:

Large community	\$17,084
Medium-size community	18,086
Small community	17,280

During the second year and thereafter, doctors in medium-size communities (from 25,000 to 250,000 population) are apt to do best. But the small-town doctor may well save more of what he makes, since he has lower living expenses.

Optimism Justified

The above summary of the first two years shows why today's new doctor has good reason to be optimistic. Not one of the 140-odd surveyed beginners failed to build at least a moderately successful practice within twenty-four months.

Why did some do much better than others? The doctor's specialty and the demand for it in his chosen locality played their part. So, of course, did his own skill and personality.

These and other contributing factors are illustrated in five case histories to be presented in subsequent issues of this magazine.

END



OVERDUE ACCOUNTS:

What Are They Worth?

You stand to collect only 71 cents on the dollar on bills that patients haven't paid for six months. Here's how the value of your unpaid accounts drops

How many cents on the dollar are you likely to collect on patients' overdue accounts? You'll get a fairly good idea from the accompanying table of collection ratios for doctors' bills, gleaned from the records of the Medical-Dental-Hospital Bureaus of America.

These figures, says the association, are as "accurate as can be developed" for the U.S. medical profession at large. But, of course, the individual M.D. can expect *his* returns to differ somewhat from the over-all averages—depending on such variables as experience, type of practice, and location.

Age of Account	Its Current Value (Per Dollar)
2 months	\$.90
4 months .....	.81
6 months .....	.71
8 months .....	.62
10 months .....	.53
1 year .....	.45
2 years .....	.23
3 years .....	.15
4 years .....	.07
5 years	0



Patients Say You

They may if you make any of these five management mistakes—each based on a good idea badly applied

By Horace Cotton

Don't get me wrong. I'm as strongly in favor of efficiency as of home and Mother. It's my job to help doctors practice more efficiently. But I'm convinced that efficiency *misapplied* is worse than none at all.

If a streamlined office procedure doesn't clearly benefit your patients as well as you, watch out! You may be courting an unlovely reputation for sacrificing medicine to money.

Nothing's more efficient than a cash register, for instance. But I'm sure you'll agree that patients don't like seeing one in a doctor's office. Only recently, I persuaded a physician I know to get rid of his. It was the real thing—complete with bell, shoot-out drawer, and all. I wonder

THE AUTHOR heads Professional Management of Southern Pines, N.C.

Say You're Too Businesslike?

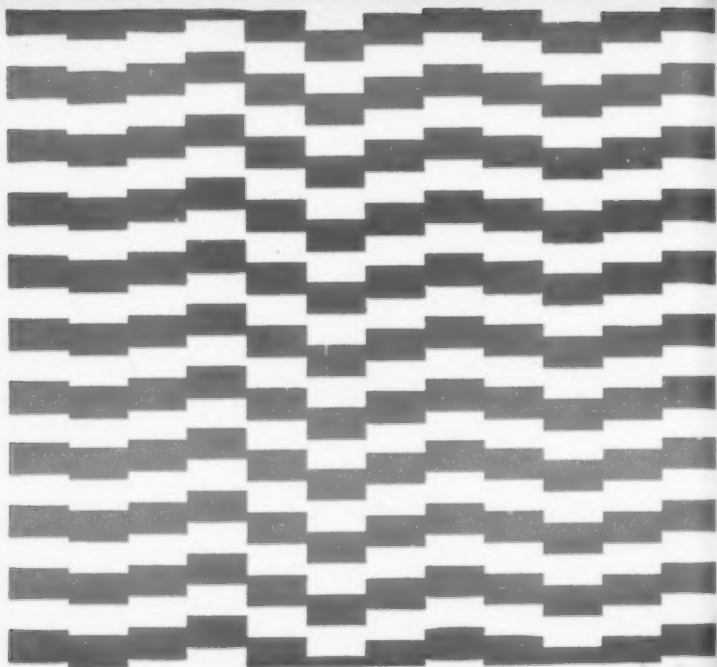
how many shuddering patients this efficient machine may have cost him.

Or take another physician of my acquaintance: He thought he could make his office function more smoothly by sending out bills on the very day of treatment. "It's a psychological fact," I explained to him, "that many patients are glad to pay cash at the end of a visit, but they'll resent a doctor whose bill arrives in the next day's mail."

Efficiency that smacks of money-grubbing defeats its own purpose. Once the patient suspects you're more interested in your own well-being than in his being well, you can be sure you've made a mistake in the streamlining process.

I've seen that sort of thing happen with an occasional client who has misapplied advice I've given him. He has taken a simple suggestion for improving his office routine and followed it too literally. As a result, he has landed in hot water.

Let me give you some examples of how doctor-clients of mine have misinterpreted suggestions for more effi-



rational adjunct to tranquilizing therapy

According to Campbell the more tense the patient and the longer the duration of his anxiety, the greater will be the nutritive requirements.¹

STRESSCAPS replenish the specific vitamin losses sustained by tense, anxious patients, increasing their resilience to stress situations. STRESSCAPS provide generous amounts of B-vitamins and vitamin C in a professionally accepted formulation.

1. Campbell, D. G.: In: *Modern Nutrition in Health and Disease*, Wohl, G. M. and Goodhart, R. S. (Editors), Lea & Febiger, Philadelphia, 1955, p. 814.

Each Capsule Contains:

Thiamine Mononitrate (B ₁)	10 mg.
Riboflavin (B ₂)	10 mg.
Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B ₆)	2 mg.
Vitamin B ₁₂	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

Average Dose: 1-2 capsules daily.

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- Infection
- Physiologic Trauma
- Endocrine Dysfunction
- Emotional Stress
- Pre- and Postoperatively

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DO THEY SAY YOU'RE TOO BUSINESSLIKE?

cient office management. In each case, I'll begin with the advice (which I happen to believe was *good* advice). Then I'll tell how it was wrongly applied.

1. *Work by appointment.* Dr. Peterson complained that his reception room was beginning to resemble a subway crush. So I recommended that he switch from open office hours to appointments. And he did so.

It Worked, All Right

At first, the new system worked like a charm. Though the doctor's office was less

crowded, he actually saw more patients and did a better job of doctoring. But after a few months, some of his patients drifted away. The drift soon threatened to become a stampede.

Finally, he sent me a rather angry S.O.S., and I dropped everything and went over. But before seeing the doctor himself, I had a chat with his secretary and a brief look at her appointment book.

Which gave the answer: Dr. Peterson had made the schedule his god. The girl had been filling

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the book to the brim for each upcoming week.

"Had to turn anyone down?" I asked her.

"Yes, but what can I do?" she replied. "The doctor says he wants his day completely organized, the way you suggested."

No, Not That!

But I hadn't advised him to make it impossible for a patient to see him in less than a week. I'd assumed he knew far better than I that illness, or fancied illness, won't wait that long for attention. That's why a too rigid appointment system is a bad idea.

Nowadays, the doctor's aide leaves some blanks in the appointment book. Dr. Peterson knows most of them will usually get filled at the last minute. If they stay empty, he catches up on his medical reading.

2. *Discuss fees in advance.* As a first-rate surgeon, Dr. Vines charges pretty high fees for our part of the country. But he never used to tell patients what his fee would be. "First let's get you fixed up," he'd say. "We can talk about the bill later. It won't be more than you can manage."

After I'd convinced him it's good public relations not to keep

patients in the dark about charges, he became an ardent advocate of prior fee talk. But note that I say "talk," not "discussion." Here's what actually happened:

One day, a patient thanked him for telling her about a needed operation and added, "I'll think it over and let you know." The next thing the doctor knew, she'd had the operation—but another surgeon had done it.

What's more, the woman had told her friends that Dr. Vines was "mercenary." He phoned me in high dudgeon. "Nobody's ever called me that before!" he blazed.

So I asked him: "Doctor, what is it you now say to patients about your fees?"

"Why, just what you advised me to," he answered. "I tell 'em the gallbladder has to come out and my fee will be \$300."

The Right Vein

I groaned. What I'd really suggested was that he begin by explaining to the patient *why* the gallbladder should come out. Then, I'd said, he should go on in the following vein: "Now, you'll be a few days in the hospital, and afterward away from the

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TOO BUSINESSLIKE?

office a while longer. Will that cause a financial crisis?"

I'd told the doctor that the answer should cue him to follow with:

"There'll also be my charge, of course. Want some idea of what the whole thing will cost—hospital anesthetist, surgeon, and everything?" After he'd talked about the other costs, I'd said, it would seem natural to name his own charge.

If Dr. Vines had followed the idea through, he'd have had no trouble. He [MORE ON 191]

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How to Pick a Lawyer

Here are tips on what to look for in a legal adviser: his availability, his background, his attitude toward fee discussions, etc.



By Michael Fooner

Dr. Benson accepted an invitation to discuss the subject of chiropractic at a public meeting. He considered submitting an advance copy of his talk to an attorney to see whether it included any libelous statements. But since he had no regular lawyer and hesitated to call on a stranger, he did nothing about it.

Result: The doctor became defendant in a suit for defamation of character.

He now has a legal adviser. "We doctors all agree that every layman should have a family physician whom he can call whenever he needs help," Dr. Benson says. "I

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HOW TO PICK A LAWYER

think we ought to realize that we doctors need family lawyers in the same way."

But how do you go about choosing the right man? Since a doctor's legal problems are likely to be of a fairly special nature, you may feel that your regular lawyer ought to be some sort of specialist. Actually, this isn't generally true.

It's quite all right, for example, to ask a lawyer who's an expert on trusts what you should do about legal difficulties you're having with your landlord. Most lawyers are, so to speak, "G.P.s";

they're able to handle all kinds of legal matters.

If your attorney should find it necessary to call in a colleague, he'd usually tell you about it and charge you what lawyers call a "forwarding" fee for any help the other man gives him. In the practice of law, such fees aren't considered unethical. So, when choosing an attorney, you probably won't have to worry about whether he's an expert on malpractice charges or income tax cases.

What yardsticks *should* you use? MORE ►

In a recent study¹ coitus was made possible in 85% of 67 cases of impotency with the use of 1 cc. of GLUKOR intramuscularly twice weekly, and maintained once weekly or as little as once monthly. GLUKOR was effective in 88.5% of

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Gold, W. L.: Impotence, M. Times 84:302 Mar. '56. Personal Communications from 110 Physicians.

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HOW TO PICK A LAWYER

MEDICAL ECONOMICS recently asked a number of doctors and attorneys this question. Here's a composite of their replies as to the kind of men they felt you should look for:

One Who's Not Too Busy

Pick a lawyer who's readily available. This means a man who has time to see you and listen to your problems. You're apt to need an ear more often than you need an advocate in court. If an attorney's practice is too heavy, you may never feel sure his best thought and attention are being devoted to you.

Says one doctor: "It seemed to me I was always having to tell my lawyer about pressing legal problems on the run. He was always 'late for an important conference,' or 'very busy on a really big case.' I finally had to find another man."

In the same way, you'll want a man who practices *in* his office, not out of it. Take the case of a surgeon who wrote an informal note to a patient who was disputing a bill. Later, when the doctor decided he'd have to sue to collect, he found that what he'd written could be used as strong evidence for a substantial reduction in the debt.

Why hadn't he asked his at-

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HOW TO PICK A LAWYER

torney about the note before sending it? He *had* called him—twice. But each time the lawyer was “out on a big case” and hadn’t bothered to call back. So the surgeon had gone ahead on his own.

Someone You Like

Pick a lawyer who’s interested in your kind of problems—and also in you. More than that, you ought to like him, too. No amount of technical ability can compensate for a deficiency in personal regard.

One M.D. tells of his efforts to

get along with a lawyer whose mother had died on the operating table ten years earlier. “It was hopeless,” he says. “The man felt a real hostility toward the medical profession. It came out in many ways, and I had to give him up.”

The best lawyer for you is the one with a basic interest in the type of work you’ll take to him—work that may include all kinds of legal problems, big and small. Ideally, he’ll be a practical, common-sense attorney, to whom you can entrust all your personal and professional affairs. MORE▶



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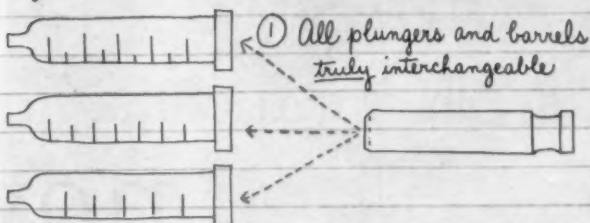
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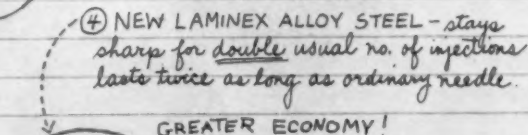
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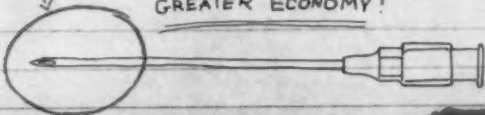
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Dosage: One tablet three times daily.

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Clinicians employing KUTAPRESSIN* in treatment of dermatitis due to poison ivy, poison sumac and poison oak found that after a single injection of 2-5 cc., vesicles and bullae were rapidly ameliorated, and itching and pain quickly subsided.

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¹Barksdale, E. E.: South. Med. J. 50: 1524, 1957.

²Kozelka, A. W., and Marshall W.: Clin. Med. 5: 425, 1956.

*Derivative of liver which normalizes arterioles and capillaries without raising systemic blood pressure.

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HOW TO PICK A LAWYER

This means, of course, that you'll probably do well to avoid the attorney-scholar who's interested only in theories of higher jurisprudence; or the compulsive character who likes to appeal every case to a higher court, regardless of cost; or the Perry Mason type who shines in dramatic courtroom action but hates desk work.

Check on His Experience

Pick a lawyer with a solid professional background. The man you're looking for should be familiar with the usual legal problems that are likely to arise. And he should be adept at dealing with them through the quickest and most effective channels.

For example, does he know people in legal, political, and financial circles? If so, he can save you time and money.

One way to get a line on the professional background of a given man: Look him up in the Martindale-Hubbell Law Directory. This three-volume work (found chiefly in law libraries) not only lists all American lawyers but also rates them as to experience and reputation.

Pick a lawyer who's already well-established. The state of his pocketbook should be healthy. If it isn't, he may at times be so

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HOW TO PICK A LAWYER

eager for a wind-up of your legal troubles—and the payment of your bill—that he'll be forced to deprive you of benefits you're legitimately entitled to. In other words, he may be overwilling to negotiate for a quick settlement.

In one such case, a physician not long ago accepted a \$3,000 settlement for injuries he'd sustained in a railroad wreck. Later, he discovered that a fellow passenger with similar injuries had been awarded \$8,500. Reason: The doctor's lawyer had been in a tight position financially and had been in a hurry. But the at-

torney for the other passenger, uninfluenced by personal money problems, had urged his client to hold out for a larger amount.

Will He Talk Money?

Pick a lawyer on the basis of his readiness to discuss fees frankly. The competent lawyer is as willing as the competent doctor to estimate charges in advance. He'll explain that there are standard fees for certain types of legal services—a fixed percentage of the estate, for instance, in inheritance matters, or a fixed sum for the preparation

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of such documents as deeds, bills of sale, and the drawing up of simple wills. And he'll be glad to discuss what sort of work he'll prefer to do for you on a contingency basis, as compared with the jobs for which his fee will probably depend on the amount of time and labor involved.

Clearly, it's to your advantage

to find a man who isn't vague about the question of money. An important ingredient in the success of any client-lawyer relationship is confidence. There can't be complete confidence unless you believe your lawyer charges a fair price for a given professional service.

So you may as well tell any



"Don't try to fool me with that mask. I've read *all* about ghost surgery."

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when **“hay fever”**
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Tedral is now also available as **Tedral anti-H** — Tedral combined with the antihistaminic *chlorpheniramine maleate*. This convenient new companion to regular Tedral is indicated

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HOW TO PICK A LAWYER

man you're considering how you feel about it. He'll prefer it that way—if he's really the man for you.

By now the qualities you're looking for in a lawyer should be pretty clear. But where, you ask, will you find the individual who fills the bill? One of the following sources should help you:

Whom to Ask

1. Friends and relatives. Consider first a member of your family, a close acquaintance, or a fellow member of a social or church organization. Here you have the advantage of knowing a good deal about the man and about whether he'll fill your needs.

Maybe you shy away from entering into such a relationship, fearing embarrassing breaches of confidence. Or maybe you believe it might someday be your awkward duty to break with the man and thus to lose his friendship.

Even so, at least one psychiatrist recommends such a choice highly. It's his theory that mutual confidence is likely to be stronger between people bound together by strong ties than between strangers.

In any case, friends or relatives can usually supply you with the names of a number of good



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Benadryl® Hydrochloride with Zirconium
cream · lotion

Compounded *specifically* for use in prevention of and treatment for "ivy and oak" dermatoses, ZIRADRYL:

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ZIRADRYL Cream is supplied in 1-oz. tubes.

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1. Within one hour, more than double the amount of salicylate appears in the blood stream.
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Prescribe ASCRIPTIN-Rorer for the pains and discomfort of arthritis, rheumatism, colds, grippe, headache, Asian Influenza, muscular aches and pains, etc. Your patients will be grateful.

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HOW TO PICK A LAWYER

lawyers. You can then look into their suitability.

2. *Patients.* You may be overlooking a good bet just because you're used to thinking of your patients only as patients. One of them may be an excellent lawyer. Here, again, you have an advantage: You'll know a lot about his attitudes, interests, etc.

If you feel that a lawyer-client relationship between doctor and patient would be an uncomfortable one, you can still ask the patient to suggest another name. (It might prove embarrassing to do so if the lawyer is in local private practice himself—but a fine idea if he works entirely for a corporation.)

Your Own Circle

3. *Colleagues, businessmen, banks.* A generally useful method of finding a lawyer is simply to inquire around among your fellow physicians, businessmen-friends, and other people you respect. They'll not only come up with specific names but also give you instances of how certain attorneys handle problems like yours.

If you're a stranger in the community and don't have such contacts, the best place to ask about lawyers may be the neighborhood banks. **MORE►**

TIMOTHY

common cause of

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commonly prescribed for relief

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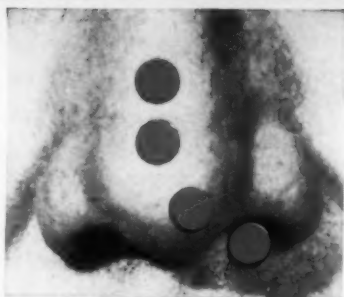
HOW TO PICK A LAWYER

4. *Law school faculty.* The law school nearest you will be glad to supply the names of competent local attorneys. Even if it's a night school or one of the many that aren't nationally famous, you'll probably be on safe ground. For such schools often thrive chiefly as a result of employing highly practical lawyers as instructors.

Incidentally, in most places—though by no means all—the county bar association may not be of much help to you, unless you're interested in hiring a lawyer in a distant community. In that case, the association can give you a list of recommended attorneys there. But in your own county it may prefer not to favor one dues-paying member over another.

Remember that it may be a real lifesaver to have an established relationship with an attorney *before* you need one. Otherwise, you may find yourself using your own "common sense" in working out what is essentially a legal matter. "Common-sense" legal opinions are about as valid as "common-sense" medical judgments by laymen. Sooner or later, you'll talk or write yourself into trouble.

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HOW TO PICK A LAWYER

pairs to his car when it was hit by an uninsured driver. Any lawyer could have told him that his state's financial responsibility law provided an almost foolproof method of getting reimbursement from any job-holding defendant.

Misunderstood Fees

But the doctor didn't want to bother any strange attorney on such a small matter. (He had some idea that the lawyer would ask for a \$100 retainer. The notion was false, but many doctors suffer from such delusions about legal fees.) So he did nothing but

write futile letters to the defendant and pay the garageman out of his own pocket.

Every doctor urges his patient to have that little wart removed *before* it becomes malignant, to take it easy *before* the coronary attack develops or the potential chest lesion becomes activated, to have the hernia repaired *before* it strangulates.

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1. Strauss, B., Clin. Med., Vol. IV, No. 3, 1957

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PUBLISHED REFERENCES: 1. Carpenter, E. D.: *Southern Medical Journal* 51:107, 1958. 2. Peryath, H. F.: *J.A.M.A.* 107:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: *J. Pharm. & Exper. Therap.* 110:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: *J. Am. Pharm. Assoc., Sci. Ed.* 48:374, 1957. 5. O'Donohy, D. E., and Shalish, C. D.: *J.A.M.A.* 107:160, 1958. 6. Furb, H. W.: *J.A.M.A.* 107:160, 1958. 7. Truitt, E. B., Jr., and Patterson, R. D.: *Proc. Soc. Exper. Biol. & Med.* 95:425, 1957. 8. Truitt, E. B., Jr., Patterson, R. D., Morgan, A. M., and Little, J. M.: *J. Pharm. & Exper. Therap.* 110:160, 1957.

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		"marked"	moderate	slight	none
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STUDY 2² Herniated disc Ligamentous strains Torticollis Whiplash injury Contusions, fractures, and muscle soreness due to accidents	39 8 3 3 5	25 4 3 2 3	13 4 — 1 2	— — — — —	1 — — — —
STUDY 3³ Herniated disc Acute fibromyositis Torticollis	8 8 1	6 8 —	2 — —	— — 1	— — —
STUDY 4⁴ Pyramidal tract and acute myalgic disorders	39	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."⁶

The Case ☒ FOR ☐ AGAINST

The A.M.A. is trying to write a nation-wide value scale to help you set fees. Here are one doctor's arguments in behalf of this idea

By Barrett A. Nelson, M.D.

You probably have a pretty good idea of what a relative value scale is, and of how it differs from a fee schedule. (If you've forgotten, the box on pages 132 and 133 will refresh your memory.) Actually, if you live in certain parts of the country, you may already be using a scale somewhat like this.

A few weeks ago, for instance, we Kansas doctors followed the example of our California colleagues and approved a relative value scale for use in our state. Massa-

THE AUTHOR, a Manhattan, Kan., surgeon, is a former president of his state's Blue Shield plan and a former vice president of the National Blue Shield Commission. He has recently completed a term as president of his state medical society. In a later issue, another medical leader will sum up the case against a national relative value scale.

National Relative Value Scale

chusetts and Michigan physicians are working on similar scales for their areas.

In addition, there's now talk of establishing a *national* relative value scale. The A.M.A. Committee on Medical Practices is trying to write a scale that could be used by doctors from New Hampshire to New Mexico. If the committee succeeds, there are indications its work will be approved by the A.M.A. House of Delegates.

Yet you may not be convinced of the worth of such a project. I know doctors who aren't. If you're among them, I believe you're mistaken. Let me tell you why.

I'm not a member of the A.M.A. committee nor of its House of Delegates. But during my tenure as president of the state medical society, I've studied both the problem and the importance of establishing relative values among various kinds of fees. What I've learned has made me certain the entire profession will benefit from a national relative value scale.

What I particularly hope is that the A.M.A. committee

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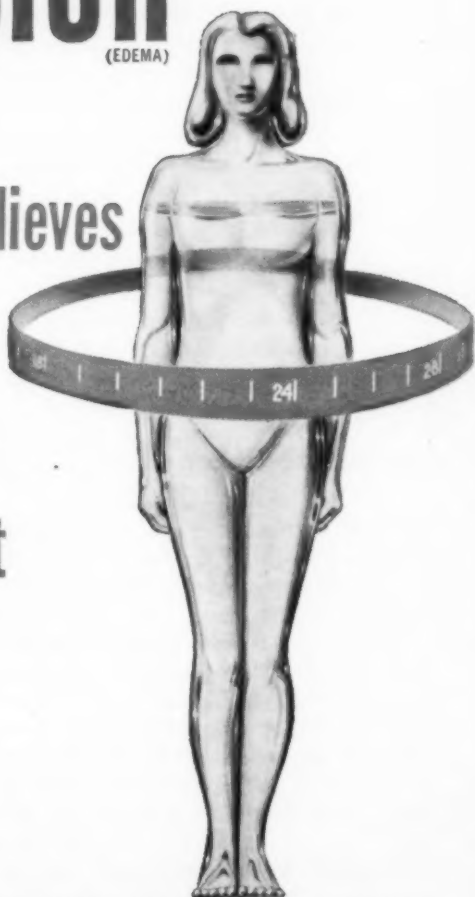
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MEDICAL ECONOMICS • JULY 7, 1958 131

What a Relative Value

A relative value scale relates the worth of one procedure to other procedures by means of a point system. Under the well-known California scale, for example, a routine hospital visit is valued at one point, a late-night house call at two and a half points, a complete history and physical at five points.

To use such a scale, the doctor begins by putting his own dollar value on a basic procedure (perhaps one that rates a single point). To determine what might be a reasonable charge for another procedure, he then multiplies the dollar value of the single-point procedure by the number of points allotted to the second procedure. For example, a rural doctor may charge \$3 for a hospital visit. According to the California scale, he might therefore charge \$7.50 for a night house call and \$15 for the history and physical. An urban

can write a scale that relates *all* procedures—whether medical, surgical, pathological, or radiological—to one another.

California's doctors haven't gone that far. They have four separate scales, relating the procedures in each scale only to others in the same scale. But I know all four can be correlated into one. We've done it in Kansas.

Even if the A.M.A. follows the

California system rather than ours, the nation's doctors stand to gain a lot. But if, as I hope, the Association approves an all-inclusive scale, I believe you'll benefit from it in the following ways:

1. A national relative value scale will help you set your fees.

To begin with, take the man who's just started practice. He has seldom thought much about the relative economic values of, say, an appendectomy and a

Relative Value Scale Is

doctor might ask \$4, \$10, and \$20 for these three services.

Obviously, a relative value scale doesn't try to standardize fees. What it does tend to standardize is relationships among fees. The idea is that a hospital visit, say, *in relation to a night house call*, is usually no more difficult for one doctor than for another.

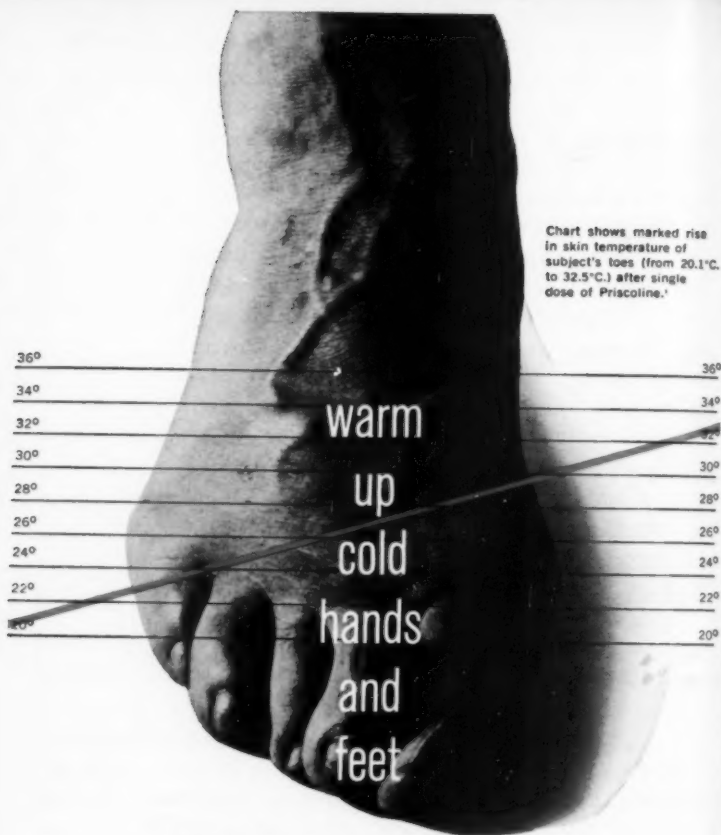
Do relative value scales relate medical procedures not only to other medical procedures but also to surgical procedures and the like? California's scale doesn't. Doctors in that state have four separate scales—one each for medical, surgical, pathological, and radiological procedures. But Kansas' new relative value scale is a single one that tries to incorporate all possible relationships. Many doctors apparently hope the A.M.A. will write a scale along the latter lines.

breast biopsy, or an appendectomy and a house call. If he asks his colleagues what fee relationships they establish among various procedures, he often gets conflicting advice.

So he must set his fees with the help of a large dose of guesswork. Sometimes he underrates the importance of certain procedures and loses money. Sometimes he overrates them and loses patients. A relative value scale

will help him avoid both pitfalls.

Or take the older doctor who moves to a new locale. Not long ago, I asked an OB/Gyn. man from a near-by state to join my group practice. He soon indicated he wasn't sure what fees would be appropriate locally for certain gynecologic procedures. After a good deal of talk with his new colleagues, he worked up a satisfactory fee schedule. But he'd have saved much time and



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1. Reedy, W. J.: J. Lab. & Clin. Med. 37:365 (March) 1951.

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trouble if he'd had our current relative value scale as a guide.

Even the well-established doctor can put such a scale to a good use. Some months ago, for example, I operated on an eighteen-month-old baby for cancer of the kidney. In twenty-five years of practice, I'd never before run across a cancerous kidney in such an infant.

It was extremely hard to decide on a fair fee when it came time to bill the parents. I'd have felt much more secure if I'd had some guidance from a value scale to which all or most of my colleagues subscribed.

For that matter, a national relative value scale would probably be of help to established doctors in a number of routine procedures. For instance, when we Kansans were devising our scale, we took a good, long look at California's, so as to compare that state's estimates of relative values with our own. So much careful research had gone into the California scales that our own job was greatly eased. We were able to adopt the recently revised California scales to our needs by making only a limited number of changes and then correlating the four separate scales into one.

As a result, Kansas doctors now have a firm basis on which to adjust fees. And many of my colleagues have already discovered that they've been charging less for certain procedures than those procedures are probably worth.

Helps Explain Fees

2. The value scale will help you justify fees to puzzled patients.

Again, let me illustrate from my own practice:

A few months after doing a routine appendectomy for a certain patient, I did a difficult gallbladder removal for another member of his family. Neither of them could understand why I charged roughly twice as much for the second operation as for the first. So I had to go to great lengths to explain the difference between the two procedures. Even then, I suspected they thought me less fair in the second case than some other surgeon might have been.

A relative value scale would have shown them the economic relationship of the two operations in black and white. It would have made it clear I wasn't being arbitrary but was doing what any

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RELATIVE VALUE SCALE?

other doctor would have done in similar circumstances.

3. *A national scale will boost collections. And it may help destroy public suspicion that the medical profession is too mercenary.* Some patients feel doctors try to capitalize on illness, especially when major procedures are called for. I believe they'll pay their bills more willingly once they're made to realize the relative importance or difficulty of a given procedure.

They'll also be less likely to appeal to medical grievance committees. When they do appeal, an accused physician will be in a better position to defend himself. (Or if his charges are out of line, the grievance committee will have an easier time showing him why.)

Fewer Court Cases

I also foresee a drop in malpractice actions—and in the number of verdicts returned against doctors. Frequently, the patient who's irritated over what he considers less-than-perfect medical results is further incensed because he thinks he's been overcharged. And jurors are often swayed by just such nonmedical considerations.

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A NATIONAL RELATIVE VALUE SCALE?

at least a partial answer to this problem.

4. *A national scale will help your patients evaluate insurance schedules.* You've surely known laymen who've bought health insurance that pays, say, only \$25 or \$30 toward the cost of an appendectomy. You've known them to blame not themselves nor their insurance carriers but their *doctors* when they're faced with unexpected bills as a result.

You'd Be in the Clear

Well, just suppose you had a relative value scale to show your patients before they bought insurance. They could then check related benefits for ten or twelve common procedures against a given policy's schedule of indemnities. Thus they'd be able to choose their coverage more wisely. And they wouldn't be able to hold you responsible for their mistakes.

5. *A national scale will aid you and your colleagues in setting up fairer-paying insurance schedules.* When the doctors in my state got together to work out a tentative, to-be-negotiated fee schedule for Medicare patients, they relied heavily on the California relative value scales. They

used the scales again in negotiating a new Blue Shield contract.

In both cases, the value scales made the doctors' job easier by providing a tested point of departure. And in many instances, my colleagues and I negotiated higher fees than we'd have demanded if we'd hacked out a schedule by guess and by gosh.

Family Doctors, Arise!


All U.S. physicians would stand to benefit from a national scale that gave us a yardstick for determining better insurance schedules. We could use it not only for Blue Shield and Medicare but also for Workmen's Compensation, indigent care, and the like. And do you know who among us would benefit most? Not my fellow surgeons and I, but our colleagues in general practice and internal medicine!

Why They're Not Fair

Most insurance schedules take surgical or OB procedures as a starting point. It's usually an expensive one. As a result, procedures in general and internal medicine are sometimes paid for at unreasonably low rates. If we get the kind of all-inclusive national

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A NATIONAL RELATIVE VALUE SCALE?

scale I'm hoping for, it'll do a more realistic job of relating the value of medical procedures to the value of all others.

6. *A relative value scale will increase rapport within the profession.* I think this will be especially noticeable in group practice. As you know, income division in groups is often something of a problem. Surgeons and internists are particularly apt to be at odds. The surgical men are likely to bring more money in; sometimes they feel this entitles them to take a great deal more out.

A scale that relates medical and surgical procedures to one another will do a lot to improve mutual understanding.

Are There Dangers?

Judging from the enthusiasm with which Kansas physicians have greeted their new scale, and from comments of doctors elsewhere, I'm pretty sure a national scale would be welcomed by a majority of the country's medical men. As I've said, though, there's some resistance to the idea. What's it based on?

"Once you establish relative values, you do it for all time," argues one man I know. But I see

no reason for any such fear of inflexibility. Whether it's national or local, a relative value scale must be—and will be—subject to occasional adjustment.

For instance, surgeons know that antibiotics have made bowel surgery much easier than it used to be. In other words, *in relation to other procedures*, bowel surgery is probably worth a bit less than it was some years ago. This fact is taken into account in current value scales.

Abreast of the Times

And as future advances in medical science reduce the relative value of other procedures, they'll be given changed ratings, too. No value scale is sacred and inalterable. No advocate of such scales either wants or expects any of them to be the last word.

Another objection to the idea goes this way: "Public opinion would force all doctors to go along with the relative values whether they wanted to or not." Have you heard any complaints from California's doctors on that score? I haven't.

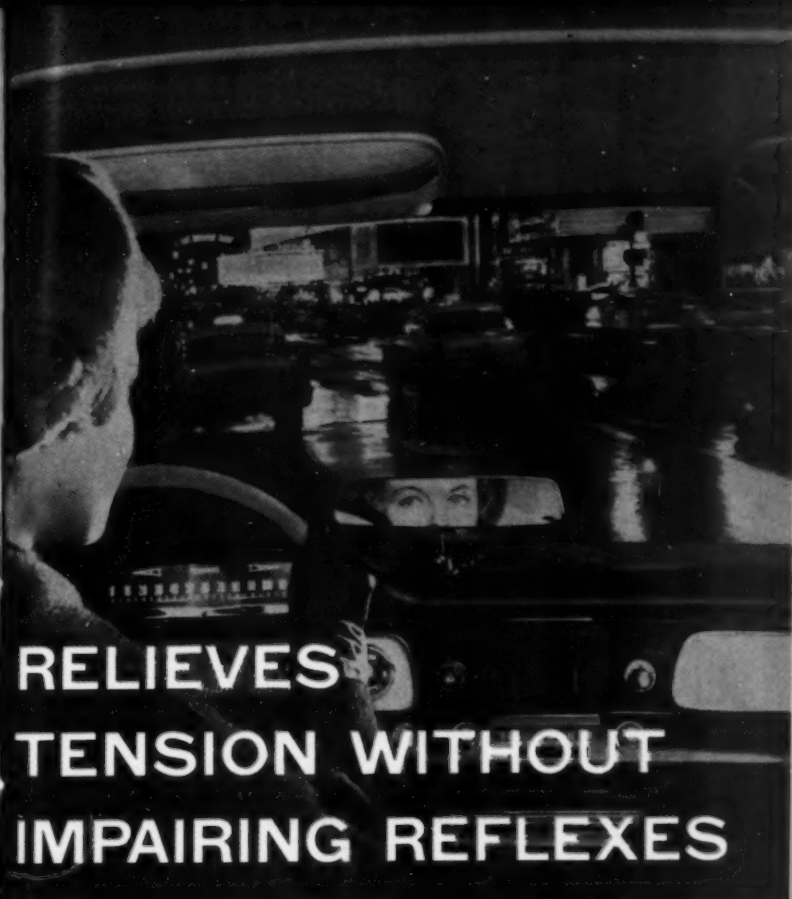
I think it's significant that not one supporter of relative value scales has ever told me he believed that such scales should be

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*Marquis, D. G., Kelly, E. L.,
Miller, J. G., Gerard, R. W.
and Benkert, A.,
Ann. New York Acad.
Sci. 67: 791, May 9, 1957.

A NATIONAL RELATIVE VALUE SCALE?

regarded as rigid schedules. On the contrary, there's widespread feeling that the scales are useful primarily as guides, and that they can be deviated from when circumstances warrant.

Art vs. Science

Circumstances sometimes do warrant in procedures where the art of medicine is as important as the science. Perhaps a national scale could emphasize this point by establishing relative values that are slightly flexible. For instance, the economic relationship of a given two procedures might

range from 1.8-2 to 1, rather than be set flatly at 2 to 1. (To suggest *widely* flexible relative values would undermine the purpose of the scale, of course.)

As for public opinion—well, we should make it plain that any national scale we adopt is meant primarily for doctors, not laymen. And we can certainly explain to the lay public why the scale must remain not a set of rules but a *guide*.

I'm glad we now have such a guide in my state. I sincerely hope we soon get one for the whole country. END

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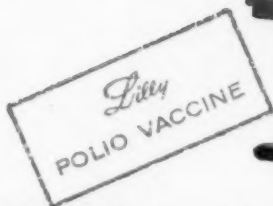
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Using a principle unique in long-acting medication, the new GRADUMET's drug release rate is not affected by the pH of gastric acidity, changes in the rate of gastric motility, or altered enzymatic activity.

metered

The inert resinous matrix which forms the porous GRADUMET itself is impregnated with 50 mg. of the anticholinergic, TRAL. On contact with any liquid (in this case, gastric fluid), a therapeutic amount of TRAL is released immediately.

release

Continuing, maintenance amounts of TRAL are released steadily, smoothly, over the next 8 to 12 hours, as the gastric fluid gradually penetrates to the innermost recesses of the GRADUMET.

sustains

The GRADUMET's release process—a *physical* rather than chemical one—is not dependent on the dissolution of successive layers or various thicknesses of coatings, as in enteric coated drug forms. The GRADUMET release rate is *controlled*—by the delicate balance between the solubility of TRAL and the porosity of the GRADUMET.

anticholinergic

Now, The TRAL Patient can be given immediate, yet prolonged, relief simultaneously, often taking him completely through the day—or night—on a single dose. No other long-acting dosage form provides more completely *controlled* drug release; no other anticholinergic offers higher clinical efficiency with less likelihood of troublesome side effects.

effect

New GRADUMET TRAL, 50 mg., is supplied at all pharmacies in bottles of 50 and 500. Filmtab® TRAL, 25 mg., and Filmtab TRAL, 25 mg. with Phenobarbital, 15 mg., are also available, in bottles of 100 and 1,000.

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®GRADUMET—LONG-RELEASE DOSE FORM, ABBOTT, PATENT APPLIED FOR.



Just one teaspoonful daily... stimulates appetite,
promotes growth... and corrects nutritional iron deficiency.

Troph-Iron^{*} Liquid

[B₁₂, 25 mcg.; B₁, 10 mg.; Iron (ferric pyrophosphate), 250 mg.]

Also Available: 'Troph-Iron' Tablets.

Smith Kline & French Laboratories, Philadelphia

^{*}T.M. Reg. U.S. Pat. Off.

Good System For Handling Checks

*This doctor has a black list of types of checks
he won't accept—and a set of
money-saving safeguards for the others*

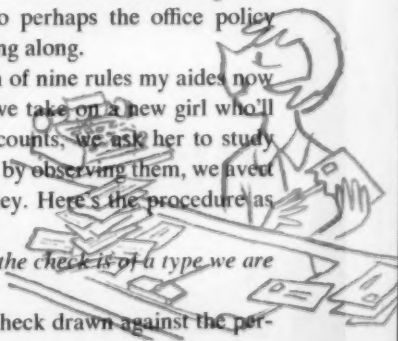
By W. B. McDonald, M.D.

Over the last decade or so, we've had a number of transactions by check in my office that were troublesome—and several that cost us money. We've learned something from each experience, though. So perhaps the office policy we've evolved is worth passing along.

This policy takes the form of nine rules my aides now follow routinely. Any time we take on a new girl who'll be dealing with patients' accounts, we ask her to study these rules. We explain how, by observing them, we avoid losses in both time and money. Here's the procedure as outlined to her:

1. We determine whether the check is of a type we are willing to accept.

Rarely do we question a check drawn against the per-



GOOD SYSTEM FOR HANDLING CHECKS

sonal account of a patient—even a new patient who's a stranger. Nor do we question cashiers' checks, certified checks, bank money orders, and travelers' checks when they're offered in payment of a bill. (Naturally, since a travelers' check must be signed by its user when first obtained and again when cashed, any aide of mine who accepts such a check asks the patient to endorse it in her presence.)

We do, however, politely but firmly refuse checks of the following types that may give trouble:

¶ Drafts on foreign banks. These are a nuisance because they're not redeemable at face value (reasons: the difference in the rate of exchange, the clearing house charge, the tax stamp that has to be purchased and affixed).

¶ Bank counter checks. Most banks honor them only when they're handed across the counter by a depositor.

¶ Payroll and Government checks from strangers. There have been too many mailbox robberies and stolen paychecks to make this a safe bet.

¶ A check made out to a pa-

new... to defeat the

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- relieves headache
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*allays migraine-induced and ergotamine-induced nausea at the same time

Supplied: 'Migral' tablets, containing ergotamine tartrate 1 mg., 'Marezine'* brand Cyclizine Hydrochloride 25 mg., and caffeine 50 mg.

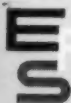


**anxiety
is the voice
of stress**

**"Anxiety, in one form or another,
is the most common symptom
confronting the practicing physician"**

1. Hollister, L.H., et al.: *Dis. Nerv. System* 17:289
(Sept.) 1956.

Whether anxiety is primary or secondary to organic illness, it is an obstacle to successful treatment. EQUANIL alleviates stress reactions; reduces anxiety, tension, and insomnia, and thus contributes to total patient management. Of all ataractic drugs, EQUANIL has the broadest usage in the common problems of everyday practice.



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Equanil
Meprobamate

**Relieves tension—
mental and muscular**

tient by a third party. To deposit such a check I would have to endorse it personally. Then if it bounced, it would bounce back to me—and I'd find myself involved in a tangle I had nothing to do with.

¶ A check marked "Paid in full," when there has been disagreement over the amount due.

They Look for Errors

2. *We make sure the check is filled out correctly.*

Since minor irregularities can cause checks to be questioned at the bank, any aide of mine who issues or accepts a check always takes time to:

¶ Examine it for erasures, corrections, or alterations that might void it.

¶ Check the date. Since some banks penalize a depositor a couple of dollars if he issues a post-dated check, we make a practice of not accepting such a check without at least pointing out this possible penalty to the patient who offers it. If a person antedates a check for us, we may point out this slip also; for the check may then be too old to cash. (Most banks will honor checks from three to six months old; but some have a thirty-day limit.)

¶ Verify the figures. If the written amount differs from the numerical amount, the check may be refused.

¶ Compare the signature with the name imprinted on the check. "Richard Kane" or "Dick Kane" may not be accepted if the bank records show the account in the name of "Richard T. Kane."

3. *We rarely accept a check for an amount larger than the payment being made.*

Some years ago I operated on an elderly man and then treated him postoperatively for several months. He'd been paying his bill in \$50 installments; but several times, to save himself a trip to the bank, he gave me a check for a larger amount and I gave him the balance in cash.

Then he was killed in an automobile accident.

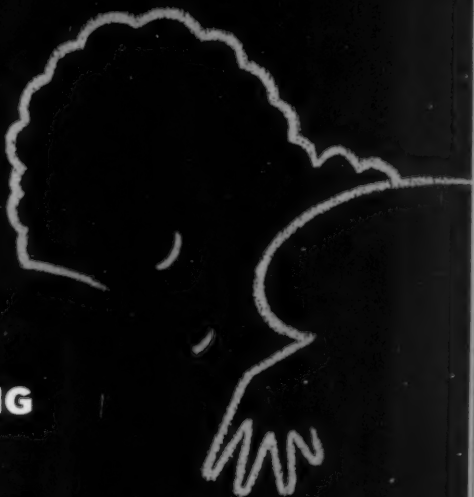
Collection Trouble

Only \$200 had been paid on his bill of \$500. So I sent the estate my statement for the \$300 balance. Back came this letter:

"Dear Doctor: We refuse to accept the bill for \$300, which you claim is outstanding against the estate of Richard Downes. The canceled checks of the deceased show that he owed you

In summer, too.

**YOU
CAN TURN OFF
THE COUGH
UNTIL MORNING**



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A 'Straslonic' Release Product • Dihydrocodeinone Resin—Phenyltoloxamine Resin

8-12 Hour Control with a Single Dose

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Supplied in Two Forms:

Each teaspoon (5cc) Tussionex liquid or Tussionex tablet contains 5 mg. dihydrocodeinone and 10 mg. phenyltoloxamine as resin complexes. Stock bottles of 16 oz. or 100 tablets.

Suggested Dose:

One teaspoon (5cc) or one tablet every 8-12 hours. May safely be adjusted to meet individual requirements.

Rx only • Class B taxable narcotic

References

- (1) Chan, Y. T. and Hays, E. E. The American Journal of the Medical Sciences, August 1957; (2) Townsend, E. H. Jr., The New England Journal of Medicine, January 9, 1958; (3) Weismiller, F., In Press; (4) Cass, Leo J. and Frederik, W. S., In Press.

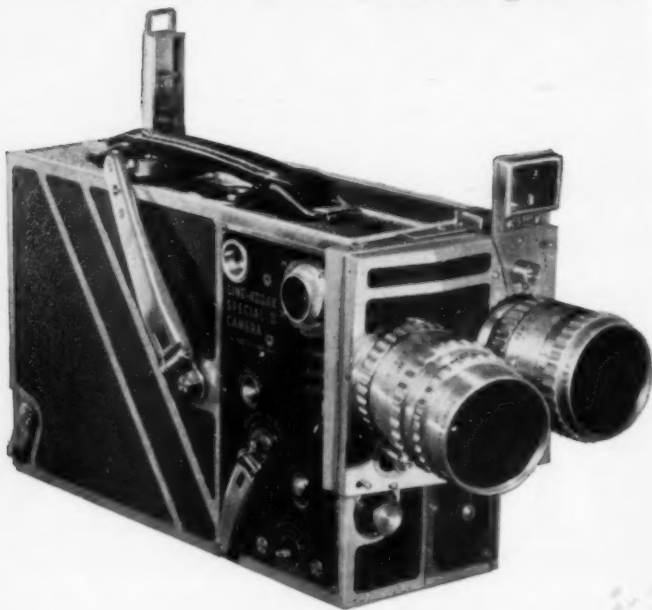
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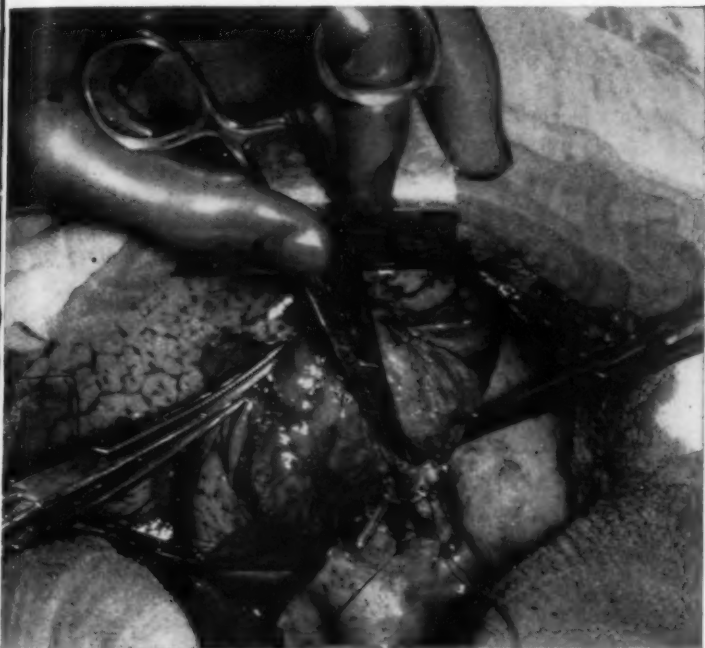
If the case is worth filming, it's worth filming with a Cine-Kodak Special II Camera. First, because as a basic 16mm camera it accepts a full range of superb Kodak Cine Ektar Lenses, and its two-lens turret accepts any combination of these lenses. Second, its reflex finder shows the exact field covered at all dis-

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Photography and Radiography

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TRADE MARK

GOOD SYSTEM FOR HANDLING CHECKS

only \$100. We suggest, therefore, that you send us a corrected bill."

My girls now have a standard explanation they offer when asked to accept a check for more than the payment being made. Such checks, they point out, lead to tax troubles, because it's hard for us to justify discrepancies between our deposits and the amounts entered on our books. As most people have a healthy fear of income-tax intricacies, this is always accepted gracefully.

To Discourage Forgers

4. We use a restrictive endorsement on our checks.

Checks are endorsed routinely in my office by means of a bank stamp: "For deposit at the First National Bank, to the account of William B. McDonald, M.D." This restrictive endorsement earmarks the checks for my account and stops a potential forger if they're lost.

Sometimes a doctor's aide who has received a check in the same amount as an owed bill will use a special endorsement—for example: "Pay to the order of General Supply Company." I don't favor this. It's another way to

disrupt a clean-cut record of receipts and disbursements. Moreover, it gives the doctor no receipt for his payment, because the canceled check is returned to the issuer.

I don't favor a simple endorsement, either. For if I merely sign my name on the back of a check, it becomes payable to anyone.

If my name's misspelled, I endorse it as it appears on the check, followed by my correct signature or the bank stamp.

Lunch-Hour Chore

5. We make bank deposits daily.

One of my aides stops at the bank with the day's deposit on her way to lunch. This lessens the chance of loss that might occur if we made deposits irregularly or at longer intervals.

We keep a carbon copy of each deposit slip; and instead of writing out the name and address of each bank, we save time by simply jotting down the transit number. This is the hyphenated figure above a line that's generally in the upper right-hand corner of the check. The first group of numerals is the symbol for the state or city; the second designates the bank. Our bank can de-

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pressures in
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*Raudixin helps
you relieve
pressures on
your patients*

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*Finnerty, F. A. Jr.; New York State J. Med. 57:2957 (Sept. 15) 1957.

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GOOD SYSTEM FOR HANDLING CHECKS

cipher the code if we need the information.

If a check is lost, we immediately notify the patient who gave it to us, so he can stop payment.

6. *We follow a standard procedure whenever a check bounces.*

If a check comes back marked "Insufficient funds," a tactful phone call or letter ordinarily rights matters. The patient's carelessness in keeping track of his bank balance usually turns out to have caused the trouble. We hold on to the check, though, until we're paid.

A check returned with "No Account" stamped on it is a much more serious matter. It obviously signals an attempt to defraud. Twice when this happened to us, the patient had skipped town. So we notified the police, the Better Business Bureau, and the local credit association, giving them as much information as possible from our records.

How We Write Checks

7. *We pay careful attention to our own check writing.*

Each of my aides knows that names and amounts on checks



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yes, any rheumatic "itis" calls for
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1. Shalowitz, M.: *Geriatrics* 11:312, 1956. 2. Warner, P. J.: *J. M. Soc. New Jersey* 54:7, 1957. 3. Hutcheon, D. E., et al.: Paper presented at Am. Soc. Pharmacol. & Exper. Therap., Nov. 8-10, 1956, French Lick, Ind. 4. Strub, I. H.: To be published. 5. Individual Case Reports to Medical Dept., Pfizer Laboratories.



PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

HANDLING CHECKS

are to be written as far to the left as possible, so that they can't readily be added to or altered. In recent years, we've been using a checkwriter as an extra safeguard against tampering. After typing in the check number, date, name, and numerical amount, the girl sets the keys for the written-out amount and the machine fills it in—at the same time perforating both the amount and the payee's name.

Of course, a checkwriter is a matter of personal choice, not a necessity. If you prefer not to buy one, your bank may be able to supply you with tamperproof checks specially treated so that attempted erasures or alterations will show.

MORE▶

*Fight
Mental Illness*



**National Association
for Mental Health**

GOOD SYSTEM FOR HANDLING CHECKS

If not, then a check puncher may be a good investment. This doesn't fill in the amount, but it does perforate the name and amount, thus making it hard, if not impossible, for the potential check raiser or manipulator to do his stuff.

Before detaching the check, my aide fills in the stub completely, giving full details to show what the payment is for. If she happens to make an error, she destroys the check and marks the stub "Void."

8. I never sign a blank check.

If I'm going to be away, all payroll checks and checks for bills that will come due in my absence are made up for me to sign before I leave. I never, in any circumstances, give a signed blank check to anyone (even my

most trusted associate). If such a check were ever lost or stolen, my entire bank balance could be wiped out.

9. I use two different signatures.

With the number of prescriptions that a doctor writes daily, he's particularly vulnerable to forgery. A colleague of mine practices in a resort town and has a large transient practice. He had his signature forged just this past summer.

Taking a tip from his experience, I now sign my prescriptions and correspondence "W. B. McDonald, M.D." and my checks "William B. McDonald, M.D." A forger probably wouldn't know this. It's just one more precaution that seems to me to make good sense. END

Don't Waste the Medicine

Here's an unlikely but locally vouched-for story I'd like to pass along:

After a long and unusually hard day, a pediatrician trudged home and quickly crawled into bed. At 3 A.M. he was awakened by a phone call from a frantic mother. "Doctor!" she cried. "My little 3-year-old boy just swallowed three baby aspirins! What shall I do?"

The doctor sighed. "Give him a headache, Madam," he replied, and hung up.

—HAROLD LAKIN, M.D.

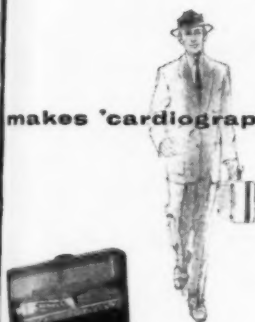
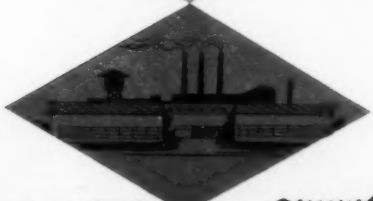
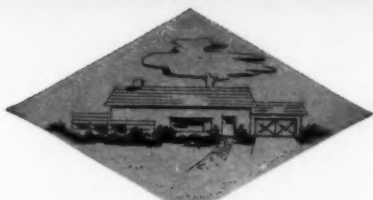
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G.P.-RUN HOSPITALS *Are Coming Back*

As a case in point, here's a good example of how generalists operate an accredited hospital and even tell board men what they're doing wrong in surgery

By John R. Lindsey

Nearly fifty years ago, Irvin S. Cobb wrote: "The general practitioner is dying out. In the city one finds him occasionally, playing a limit game in an office on a back street—two dollars to come in, five to call—but the tendency of the day is toward specialists."

Cobb saw the sweep toward specialism, all right. But he was wrong about general practice. So far, at least, the G.P. has refused to follow the dodo into extinction. In some places today, his position is even stronger than it used to be. Witness those places where the modern G.P. is organizing his own hospitals.

Why is he doing this? Because he feels he has to in the light of specialist-made restrictions in the typical institution today.

A few months ago, one of general practice's more out-

G.P.-RUN HOSPITALS ARE COMING BACK

spoken champions, Dr. Lowry H. McDaniel of Tyronza, Ark., told me about a colleague who'd been blocked out of a large city hospital. The board, said Dr. McDaniel, had adopted a rule that no G.P. could use forceps in the delivery room without getting permission from a board-certified obstetrician.

"Here's what makes this situation particularly ridiculous," he commented. "Thirty years ago, the general practitioner I'm talking about delivered the very board man to whom he must now apply for permission to use forceps. That's not all. He delivered 3,000 babies before and 3,000 babies since delivering the OB diplomate. Now he has to go back to school before he can use forceps again."

Trend Is Growing

It's in reaction against such snubs that G.P.-controlled hospitals are springing up all over the country. The trend is most pronounced in California and Florida. But it's also taking hold elsewhere, notably in the Middle West.

Many such hospitals aren't accredited. But let's take a look at one that is. We'll examine it not

as a typical G.P.-run institution but as an outstanding example of a developing trend.

Brent General Hospital in Detroit is G.P.-staffed, G.P.-operated, and fully accredited by the Joint Commission on Accreditation of Hospitals. The few board men on the forty-three-member staff are radiologists and pathologists. All the other active staff members are G.P.s.

The administrator, Dr. Morris S. Brent, is a general man, too. He calls himself "a lowly G.P.," although he has done more than 1,000 major surgical operations and an equal number of deliveries.

As one Detroit surgeon puts it, "Morris Brent knows his way around the common duct." Yet his history is much like that of other experienced generalists. After a year's training in surgery and several years in general practice, and with many major operations behind him, he experienced increasing surgical restrictions and bed denials.

So, "with others like me, who saw the handwriting on the wall and didn't like what they saw," he founded Brent General as a nonprofit corporation. At the beginning, in 1942, the hospital



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Unlike most big-city general
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tions favor the active—or G.P.
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there's a consulting staff of fifty-
four specialists.

G.P.s on the active staff are
given every chance to get experi-
ence, perfect their skills, and in-
crease their privileges. And after
they finish their residencies, they
can climb up the ladder to unlim-
ited privileges in surgery, medi-
cine, or obstetrics.

A Five-Step Ladder

Surgical privileges, for exam-
ple, are assigned according to ex-
perience and ability in five tech-
nical classifications, from "junior
surgeon" up to "full attending
surgeon." Those at the top have
unlimited privileges and serve as
preceptors for those in the four
lower classifications.

Brent General is especially
proud of its preceptor system.
The young physician is kept
tightly under his preceptor's
wing. At first he's allowed to do
only a few routine procedures
unassisted: diagnostic dilatation
and curettage, circumcisions,
tonsillectomies. Then, as he ad-

vances to the next rung, he may also attempt a regular D. & C. or appendectomy, provided the preceptor is supervising.

At the third level, he can do all routine procedures unaided. And he gets a chance to assist the top men in major surgery. Since there are no surgical residents, any physician may spend mornings as first assistant in order to advance up the surgical ladder.

Once he reaches the fourth, or next to the top, rung, the doctor's surgical privileges are unlimited. But he isn't yet permitted to serve as preceptor. At present only a few of the active staff—plus board-certified members of the courtesy staff—have top privileges.

The departments of medicine and obstetrics are run along similar lines. As in surgery, each department head is likely to be a G.P. By virtue of his position, he's also a member of the executive committee.

Thus, the G.P. on his way up has reason to feel he's being judged strictly on his merits by a jury of his peers: the G.P.-dominated executive committee and a special surgical staff committee. For its part, the hospital maintains its standards through

the preceptor system, the strictly observed gradations of privilege, and—of course—hard-working tissue and medical audit committees.

"Since surgery is obviously the most difficult area to regulate," adds Dr. Brent, "we also have strict rules on consultation in major surgery and in any extraordinary situation. We require consultation in such procedures as Caesareans, radium therapy, and pre-eclampsia—in fact, in every grave case. Our formal consultation rate works out to 20 per cent of all admissions. That's where the board men on our consulting staff come in."

G.P.s Set the Pace

Board men may be called in, too, to handle the more complicated procedures: urologic, thoracic, cardiac, and some of the heavier abdominal surgery. But at least 70 per cent of all the surgery is done by G.P.s, Dr. Brent estimates. "They do *all* the bread-and-butter surgery from hysterectomy down," he says. "And with occasional exceptions they hold *all* the medical staff offices."

Does this accent on the general practitioner make for conflict



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G.P.-RUN HOSPITALS

with the consulting staff? Not in the ordinary course of events, according to Morris Brent. "The board men are happy to serve as consultants and to do the heavier surgery. We work as a team," he explains. "The few troubles that we have are as likely as not to come from specialists making courtesy admissions."

A Special Rule

One source of trouble in this category seems to be the surgeon on his way down—the once-top man at another institution who has slipped more than he realizes. Because a few such men were too often willing to take a chance and go ahead with surgery on a 50 per cent hemoglobin, Brent General now insists on 70 per cent. Its rules state that no doctor may give anesthesia if the hemoglobin is less than 70.

But the G.P.s' aim isn't vindictiveness against their specialist colleagues. Here's how Dr. Brent puts it:

"Though it's nice to be in a position to turn the tables a bit, that's by no means our motive. What we want is to keep our accreditation and to maintain the hospital's general residency program for training more G.P.s. We're safeguarding our self-sufficiency as generalists. And we're

Documentary Case History . . .

Hypertension controlled for four years with **Serpasil**

(reserpine CIBA)



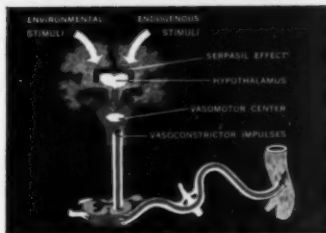
K. C., a 67-year-old retired shirt manufacturer, had a 16-year history of hypertension, was troubled by recurrent dizzy spells and headaches. "I'd get several attacks a day. . . . Usually I'd go into the bedroom and lie down." Serpasil therapy was started four years ago, effecting a gradual reduction of the patient's initial blood pressure of 220/120 mm. to the present 140/80. Now well and asymptomatic, ". . . I'm able to go to matinees and see some of the TV shows."

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Serpasil shields the psychic and somatic reaction centers from emotional and environmental stress stimuli, thereby inhibiting the discharge of vasoconstrictive impulses through the sympathetic nerves.



Adapted from Moyer, J. H., Dennis, E., and Ford, R.: Arch. Int. Med. 96:530 (Oct.) 1955.

C I B A SUMMIT, N. J.

2/5030HK

MEDICAL ECONOMICS • JULY 7, 1958 173

G.P.-RUN HOSPITALS ARE COMING BACK

confident we can go on doing it through efficient teamwork, not through petty rivalry.

"Our hospitalization committee," he adds, "is alert to over-stays and needless utilization of beds. There are regular meetings between the medical liaison committee and the nonmedical staff, to set straight any bookkeeping, admitting, nursing, housekeeping, and laboratory problems that may arise. Our social functions have created a real camaraderie among the G.P.s and the specialists at Brent General."

What of the future? Econom-

ically, the G.P.-controlled hospital seems to be a sound proposition. Dr. Brent's own hospital has doubled its bed capacity since 1950. It has hopes for further expansion on extensive acreage recently acquired in suburban Detroit. And other doctors I've talked with feel that G.P.s all over the country are bound to repeat the success of Brent General whenever they have a mind to.

"They've got the weight of numbers," one man says. "All they need is the spark."

Maybe Brent General's story will supply it.

END

Return of Service

One of my colleagues rarely makes night calls. Instead, he insists that most such patients meet him at the hospital emergency room, where he can give better service.

One recent night, he received a call from a father with a sick child. The doctor instructed the man to bundle the child in a blanket, take it to the hospital, and telephone him as soon as they arrived.

The doctor heard no more. Later he learned the father had called another M.D. to see the child.

One night not long after, the doctor's home toilet overflowed. He dialed a plumber who advertised twenty-four hour service and explained the trouble. But when he identified himself, the plumber gave an odd grunt of recognition.

"O.K.," said the plumber. "You just bundle it up in a blanket, take it down to my shop, and phone me when you get there."

—LOUIS S. MOORE, M.D.

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1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755, 1956. 2. Moyer, J. W.: M. Clin. North America, March, 1957, p. 405. [®]Trademark

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What Tax-Sheltered Investments Offer You

*Want tax-free income? Want to build up your
retirement capital? Want to create capital gains
you can cash in with the least tax loss?
Then these basic investment tips will help you*

By William J. Casey

Dr. Orville Harris mailed in his quarterly Federal income tax payment on the last possible day—Monday, June 16. "There goes another six weeks' earnings," he said to himself as he dropped the envelope in the corner mailbox.

Getting into his car and driving home, he couldn't stop thinking about it. "Let's see," he mused, "suppose I'm fortunate enough to net \$20,000 a year for the next twenty-five years. At present rates, I'll have to pay the Government . . ."

He worked out the figures in his head as he drove. Finally he came up with the discouraging answer: "I'll have to pay the Government more than \$200,000 in income taxes!"

He told this to his wife when he got home. And later

TAX-SHELTERED INVESTMENTS

that evening the subject came up again.

They were guests for dinner at another doctor's home. As the host, Dr. Homer Fisher, was carving the steak, he remarked casually: "Do you realize that this steak is worth \$1,000?"

Dr. Harris smiled grimly. "I always thought that ranch of yours was an expensive hobby."

"Oh, no!" Fisher chuckled. "The steak represents a *tax saving* of \$1,000."

Seeing that Orville Harris looked a bit puzzled, Dr. Fisher went on:

"Nothing mysterious about it. Three years ago, instead of buying stocks for dividends or buying real estate for rental income, I invested in a ranch and a herd of cattle. With a little encouragement, the cattle multiplied. Now I've just sold part of the expanded herd. The difference between my expenses and the selling price is a long-term capital gain, taxable at only 25 per cent, as against the 59 per cent tax I pay on personal income. So I figure that *in taxes alone* I've made \$1,000 on the deal."

"Sounds interesting," said Dr. Harris. "I was brooding about taxes only this afternoon."

"Don't we all?" The host shook his head. "But I've found one way to lighten the burden. I mean by looking for tax-sheltered investments."

"That sounds like banker's talk," said Dr. Harris. "Just what do you mean?"

What the Term Means

Dr. Fisher was obviously well-informed on the subject. Selecting his words with care, he said:

"Tax-sheltered is a term applied to any investment that legally provides income, or a profit, in such a way that payment of taxes on the return *is avoided or greatly reduced.*"

"Like your ranch?"

"Yes, or tax-exempt bonds, or shares in mutual funds, or any one of a number of things. Several types of investment have the tax-sheltered feature."

He hesitated for a moment. Then finally he said: "I think maybe you ought to talk to Tom Finley. Finley's the investment consultant who advised me to buy the ranch. He's been specializing in tax-sheltered investments for several years. Remind me before you go and I'll give you his address."

Dr. Harris took him up on

Now—the most widely prescribed tranquilizer¹ in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules

q. 12 h.



Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained*
basis, without between-dose interruption

*"The administration of meprobamate in
sustained action form [Meprospan] produced
a more uniform and sustained action...
these capsules offer effectiveness at
reduced dosage."*²

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.

2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

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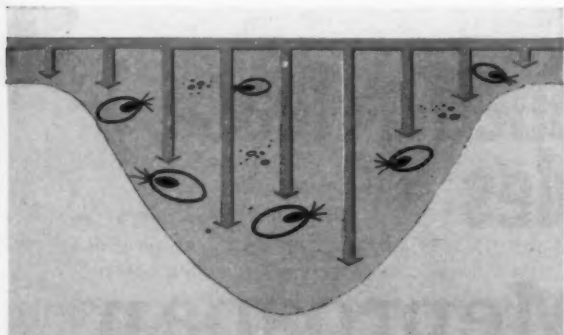
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treatment barrier of
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The trichomonad likes to wander. It hides under debris and mucus, and burrows deeply into the crypts and crevices^{1,2} of the vaginal vault "where the albumin normally present acts to protect many of the organisms from surface medication."¹

For this reason, leukorrhea has remained most obstinate until the introduction of Lycinate vaginal tablets.



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from without
then
explode the
trichomonads
from within

Lycinate, in addition to its surface active medicaments, contains lysing agents which carry the protozoacide-fungicide, Diiodohydroxyquin, through mucopurulent discharge to reach even deep-seated pathogens.

Once in contact, Lycinate dissolves cell membranes, denatures cell proteins, penetrates the pathogens, causing them to swell and explode.

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Sodium lauryl sulfate	5 mg.
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Aluminum potassium sulfate	14 mg.
Lactose	380 mg.
Dextrose, anhydrous	650 mg.

1. Davis, C. H. and Grand, C. G.: Continued Studies on the Treatment of Trichomonas Vaginalis Infections. *Am. J. Obst. & Gynec.* 68:559 (Aug.) 1954.

2. Weiner, H. H.: Treatment of Trichomonas Vaginitis. *Clin. Med.* 8:25 (Jan.) 1958.

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TAX-SHELTERED INVESTMENTS

that. And the very next day, he called on the investment consultant and outlined his problem to him in these words:

"I'm worried about my financial future. Taxes are biting deep into my personal income and also into the dividends from my investments. I'm having a hard time building up a reserve for family protection and retirement.

"I'll pay all the legal taxes I must; but I'm damned if I want to pay a cent more than absolutely necessary! Dr. Fisher told me about the advice you gave him. Can you explain how tax-

sheltered investments can help me save some money?"

"Gladly," said Finley. "But first I'd better mention the element of risk. Tax-shelter doesn't reduce the risk in any investment. On the contrary, attractive tax features in an investment may make it more, rather than less, risky."

He pulled a long sheet of paper out of a desk drawer and handed it to his visitor. "Here's a breakdown of some of the things that tax-sheltered investments can do for you," he said. "Take a look." MORE▶

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TAX-SHELTERED INVESTMENTS

The doctor read the breakdown with care. Here's what he gleaned from it:

1. Tax-sheltered investments can bring you tax-free income. This is true, for example, of tax-exempt bonds. Certain stocks also pay tax-free dividends. And life insurance, when paid to heirs, provides tax-free income for them, if not for you.

2. Tax-sheltered investments can build up your capital at low tax rates. Owning income-producing buildings, for instance, allows the doctor-investor to deduct depreciation of the property from income. Such investments often have an additional attraction for investment-minded medical men as property values improve. Repairs, which can be made with tax-deductible dollars, also build up values.

This appreciation, of course, enjoys tax-shelter because it becomes tangible only when the property is sold. Then it becomes a capital gain, taxable at the lower capital gains rate.

3. Tax-sheltered investments can create and hold capital gains while you select the most advantageous tax timetable for cashing them in.

This is a particularly useful

feature for doctors. It allows them to choose low-income years in which to take profits earned.

Breeding a herd of cattle is an example. Here time, nature, and good management work in unison. The cattle grow and multiply. They can be sold after a few years or held to breed more stock for a longer-term gain. Thus you can pick a time for sale that best suits your tax situation.

This tax-shelter device should interest the older medical man who wants to taper off his practice by taking longer vacations and working fewer hours.

It Aids Speculators

4. Tax-sheltered investments can help build your capital by making your tax dollars do double duty.

In certain enterprises, the expense of development and discovery can be charged off against income when the venture gets into the black. This offers a definite tax-shelter advantage to the doctor-investor who is willing to take a chance. But he must, at this point, weigh the pros and cons of speculation.

Suppose with a full knowledge of the risks involved, you join in putting up money to finance ex-

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Patients on 'Compazine' are, in virtually all cases, free from drowsiness, and often experience an alerting effect. They can carry on normal activity.

And, on the other hand, for the patient who cannot sleep because of anxiety and tension, one 'Compazine' Spansule capsule taken before retiring provides relief *throughout the night*.

'Compazine' Spansule capsules: 10 mg.,
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ploration for an oil-well site. Two or three drilling attempts end in expensive failure; but the fourth leads to the discovery of a profitable gusher. Tax regulations will then allow you to deduct the expenses of your unsuccessful attempts—plus the cost of drilling your successful well.

The result is a return to you (instead of to the Government) of money sunk in dry holes. You are allowed to recoup a good part of your original investment.

The Government also lets you deduct a percentage of income for "depletion." This acts (like depreciation in real estate operations) to reduce your taxes and boost your capital gains. But, again, remember the risk in such an undertaking. Only you can decide whether that risk is worth assuming.

He Got the Idea

Dr. Harris handed the paper back to Finley. "It certainly covers a lot of territory," he said.

"Yes," agreed Finley, "but the doctor who's considering tax-sheltered investments should begin by getting the broad picture.

"Your choice of investment then depends on the goal you want to head for. And that de-

pends on certain basic considerations: the nature and stability of your practice, your other investments, insurance and savings, long-term obligations, age, retirement plans, health—even your personality."

"Well, now, can you give me a few more specific tips?"

Finley leaned back in his chair and pondered the question. Then he picked up a pencil and scribbled out some notes. They added up to the following:

They Protect Principal

1. If your goal is safety of principal, consider tax-exempt securities. Income from bonds issued by states, cities, counties, and so on is not subject to Federal income taxes.

Outside of U.S. Government bonds, such securities probably have the best safety record of all classes of investments. The tax-free interest paid by these bonds often leaves the doctor who holds them with a better *net* return than the higher before-taxes yield of many good common stocks.

Take, for instance, a doctor with a taxable net income of \$20,000. He would have to realize a 7.3 per cent yield from a taxable security to equal the 3

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of famous B-D quality cotton elastic
with the added strength and holding properties
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and now...
a new reinforcement
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ACE Adherent (Aerosol)

Sprayed on affected areas before bandaging
it prevents slipping of adhesive tape,
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TAX-SHELTERED INVESTMENTS

per cent tax-free yield from a tax-exempt bond.

2. *If your goal is maximum capital gains*, consider investing in oil, cattle, and similar operations.

In the case of cattle breeding, for example, you can take advantage of depreciation allowances and natural growth; and, as we've seen, you can control

the time of sale for best net tax results. Oil operations offer parallel advantages.

This kind of investment has the tax-shelter feature of using dollars that you might otherwise have to pay out as taxes—using them to build up your total capital gain, when you choose to take it.

3. *If your goal is appreciation*



"She wants to know how much you charge for an emergency appendectomy."

when you
treat infections
in patients
such as these

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- patients on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

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Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u. per cc.), 10 cc. dropper bottles.

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TAX-SHELTERED INVESTMENTS

of capital value (for retirement, perhaps, or family security), consider insurance, timber, cattle, citrus groves, or real estate, with income applied to retire the mortgage debt.

There are substantial tax-shelter features to all such investments. Increases in value can be kept on the books and thus "tax-sheltered." The final "cashing in" can come at the doctor's option, at a time and in a form best suited to his or his family's tax situation.

For instance, you might decide to sell some real estate after your retirement from active practice. You could then arrange to be paid in several yearly installments. This would probably keep the capital gains tax at its minimum percentage.

When Dr. Harris finished reading what Finley had written, the investment consultant said:

"Since this is your first look at the tax-sheltered investment field, I'd like to say a few words of caution before we go any further.

"Tax-exempt securities have been in great demand. This also applies to ranches, farms, income-bearing real estate, and the other types of investment that we've touched on today. Don't forget that the tax appeal of an investment will, to some extent, be reflected in its price.

"In short, there are two errors you must guard against:

"1. Paying too much for the investment.

"2. Selecting it without expert and impartial advice."

"Don't worry," said Dr. Harris. "I'll go slow. I'm a real conservative. But at least you've made me realize that tax-sheltered investments offer me just the sort of financial benefits I need."

END

One Thing at a Time

A young interne was asked to draw blood from a newly admitted patient. After several unproductive punctures with the needle, the patient began to show annoyance and concern.

So with an air of great assurance, the interne said: "Well, I've made the holes. Tomorrow I'll come back and collect the blood."

—J. EUGENE LEWIS JR., M.D.

Whatever the peptic-ulcer regimen . . .

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"Machine Mimics Man" also reviews normal kidney function, the basic principles of hemodialysis, and its role in renal insufficiencies and certain systemic poisonings.

For information on scheduling the film, "Machine Mimics Man," write to Film Library, Travenol Laboratories, Inc., Morton Grove, Illinois.

Travenol Laboratories, Inc. Morton Grove, Illinois

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[CONTINUED FROM 102] learned the hard way that there's more to discussing fees than simply naming the price.

Pay As You Grow

3. *Encourage cash payments and pay-as-you-go systems.* Not long ago, I suggested to a three-man OB partnership that there was no reason why they shouldn't have practically all their money in hand before the patient's discharge from care. I explained that OB cases can be educated to pay as they grow. And I drafted a little leaflet for handing out to their patients.

When I saw a copy of the leaflet as it came from the printer, I was startled by one sentence in it. I'd written: "If you do make these payments as you go along, all you'll have to pay when the baby comes is the hospital bill. And of course the doctor will be right there to meet you at the hospital."

To this, one of my clients had added the words: "Otherwise, we cannot guarantee to be in attendance."

Would *that* have scared off mammas-to-be! Can't you hear the patients asking: "Does this mean that if I haven't paid you

by the time I get to the hospital, you won't be there?"

I asked the doctor-turned-editor why on earth he'd added the sentence. "Well," he replied, "you told me yourself that one of the main ideas was to get them to feel they'd make sure we'd be on the job by paying us more or less in advance."

True enough. But I hadn't dreamed he'd carry the idea out to any such conclusion. There's a big difference between implying there'll be a reward for good behavior and baldly threatening punishment for bad.

Those Insurance Forms

4. *Charge for filling out certain insurance forms.* Dr. Corey asked me what I thought he should do when patients had flocks of insurance forms for him to complete. So I said: "Why not do one free for any patient? But for any other such forms required in his case, you might charge him a dollar apiece to pay for your girl's time."

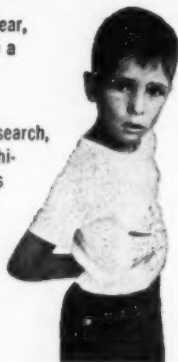
I didn't know that the small-loan agencies in Dr. Corey's town insist on sickness insurance to cover their TV loans, washing-machine loans, etc. If the debtor gets sick, the insurance

1 child in 10

... born each year,
may some day be a
mental patient!

UNLESS...

we have more research,
clinics, and psychi-
atrists to cut this
terrible toll!



Give! Mental Health Campaign



TOO BUSINESSLIKE?

pays the current installment. And the doctor has to complete a form for the patient as often as every week while the illness lasts.

As I say, I didn't know that. But the doctor did.

Even so, he took my advice literally. Even when the payments were as low as \$3 a week, he charged patients \$1 a form after the first one. Which meant that an insurance benefit of \$3 was being reduced by one-third whenever Dr. Corey signed a form.

Dollar-Greedy?

Soon, the loan agencies were advising customers that the doctor was strictly a businessman: He charged a dollar just for writing his name. The results can be imagined.

Whom did the doctor blame? Me, of course. Maybe I was at fault for not boning up on small-loan agencies. But what about Dr. Corey? Seems to me he should have realized that while it's all right to charge \$1 for a form that gets a patient, say, \$100, it's hardly fair to take \$1 out of \$3. He knows now, anyway.

5. *Get collection help when appropriate.* I'm all for the use of good collection agencies. In my book, the patient who blandly ig-

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running noses ...



and other hay fever symptoms

TRIAMINIC stops rhinorrhea, congestion, other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are usually best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

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Each timed-release TRIAMINIC Tablet contains:

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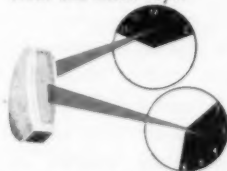
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then—3 to 4 more hours of relief from the inner core

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THEY SAY YOU'RE TOO BUSINESSLIKE?

nores bills, pleasant letters, and amiable phone calls has no kick coming if he winds up with a letter from a bill-collector.

So I advised Dr. Gordon to use a reputable agency for his delinquent accounts. He'd never done it before. But now he signed up with one.

Then, when angry complaints began coming in, he blew his stack. I went to his office to investigate. And I found he'd had his girl send the agency *every* account over six months old.

That hadn't been my idea. "Each month," I'd suggested, "your girl can give you a list of all accounts unpaid for six months. After you've crossed out any names you don't want to go to the collection agency at that time, she can send the others."

I reminded the doctor of this. "But you also advised me to delegate as much office detail as I could to my secretary," he argued. "So I delegated the collection-agency job."

There was only one answer: "Well, Doctor, if I were you, I'd delegate it back to myself. You're the only person qualified to say how far it's proper to go in collecting from a given patient."

And so it goes. Your efficiency measures are all to the good—but only as applied appropriately and in a spirit clearly understood by patients.

When your patient says, "My doctor gets things done," he's complimenting you. If he says, "My doctor seems too business-like," you may soon stop being his doctor. END

Open for Business

A young surgeon and his family recently moved into the house next to mine, and he opened his office there. One day his two small sons were playing in the front yard when a man walked up to the office entrance.

"Hey!" one of the lads greeted him. "Is my daddy going to operate on you?"

"I don't know," said the man. "I've never met your father. A friend referred me."

"Well," said the boy, "he told us that if he don't operate, we don't eat."

—JAMES V. GOWANS, M.D.

athlete's foot
is now
in season



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MEDICAL ECONOMICS • JULY 7, 1958 195

The Achievements

of Aristo

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only $\frac{2}{3}$ that of prednisone¹. . . Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*². . . absence of serious side effects specifically noted.^{1, 2, 3}

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients⁴. . . 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).⁵

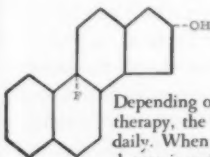
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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.⁶... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.⁷

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.^{8,9}... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.^{10,11,12}... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.¹³



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about $\frac{1}{3}$ in rheumatoid arthritis, by $\frac{1}{3}$ in allergic rhinitis and bronchial asthma, and by $\frac{1}{3}$ to $\frac{1}{2}$ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

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...then *most* babies
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ordinary milk can take
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Even in the small percentage of milk allergies, a recent study* shows that more than $\frac{3}{4}$ of such infants react only to the whey protein. Only a few casein-sensitive babies do not tolerate evaporated milk, in which whey protein is made non-allergic by heat processing.

In the rare case when allergy is narrowed to milk, trial on evaporated milk often shows the baby reacts *only to unmodified* whey protein, need not be deprived of irreplaceable milk values.

*Ratner, Bret; Crawford, L. V.; and Flynn, J. G.:
Amer. J. Dis. Child., 91:593, 1956

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*higher and higher...
till the sky tipped over...*

*then down she came into the brambles
and sharp gravel and her dress was torn and there
were cuts and scratches...along with smudges of dirt*

**moral of the story: falling from a swing is bad even for a rag doll . . .
and when real children are hurt at play, topical infections often follow.**

to prevent and control topical infections

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*...because it provides the 3 preferred
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greater antibiotic
concentrations
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Memo

FROM THE EDITORS

Unbiased Advice

Where can you get unbiased advice on business matters that are important to you?

Take investments. Maybe you've found a broker who serves you well. That's good. But sometimes you wonder how much his advice is colored by his commissions.

Or take insurance. Perhaps your personal agent is well informed. But he still represents just one company, as a rule. Is he up on the latest policies issued by others?

Sure, you need personal counsel when you buy insurance, sell stock, or engage in other business dealings. But you also need something more: a second opinion from some authoritative outside source that has no vested interest in the deal.

That's what MEDICAL ECONOMICS tries to provide. It goes to great lengths to get business articles that are both authoritative and impartial. One recent example:

"What Kind of Health and Accident Insurance?" began with a fact-gathering job. Our staff collected individual policies from all

major companies now writing this coverage. It got group contracts from sixteen medical societies. All these sources, of course, were partial to their own policies. How to evaluate them impartially?

In your behalf, we searched for an authority who was well-versed in such insurance but who didn't sell it himself. We found our man in Spencer M. Schryver, an independent insurance consultant. His evaluation made possible the down-to-earth article you probably remember in the June 9 issue.

Our other business articles develop in much the same way. Thus, you've recently received life insurance help from William J. Matteson, director of the nonprofit American Institute for Economic Research; investment help from Raymond Trigger, an independent financial editor; and tax help from René A. Wormser, LL.B., perhaps the country's top estate-planner.

Authorities like these have no axes to grind. They're free to advise doctors exactly as they think best—just as MEDICAL ECONOMICS itself is.

END